

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 2 6

1. FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMELIA LUCY NAGENGAST			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1985		2b. HOUR 11:42 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 3 1926	6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYP OF WORKING LIFE) Secretary		12b. MOVING BUSINESS OR INDUSTRY Storage Co.
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Emil St. Cross		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Gentile			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT Joseph Nagengast, Husband		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Insulin Dependent Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION Feb. 7, 1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (R) Femoral arterial occlusive Disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from February 5, 1985 , to February 11, 1985 , that (I) (we) lost saw the deceased alive on February 11, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael J. McHugh		DEGREE M.D.		22c. DATE SIGNED Day 2/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. MCHUGH		22e. ADDRESS 201 EAST UNIVERSITY PARKWAY			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2/14/85	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION Baltimore Co., Md. STATE
24. FUNERAL DIRECTOR Bruzdinski Funeral Home		25a. DATE REC'D. BY REGISTRAR FEB 15 1985		25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES L. NARVELL SR.			2a DATE OF DEATH MONTH DAY YEAR 2 15 85		2b HOUR 6:50A^M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 12 27 21		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker	12b KIND OF BUSINESS OR INDUSTRY Steel Bethlehem	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Baltimore	13c CITY OR TOWN Catonsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Erwin Narvell			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Pederson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b SOCIAL SECURITY NO. 218-09-6358		17 INFORMANT ADDRESS Mrs. Mary Narvell 619 Edmondson Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular arrhythmias Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a DATE OF OPERATION 2-13-85		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 2-12-85 , 19 85 , to 2-13-85 , 19 85 , that (I) (we) lost saw the deceased alive on 2-13-85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dinesh Ranjan		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED 2-13-85
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. DINESH RANJAN		22e ADDRESS 900 Caton Ave., Baltimore, 21229			
23a BURIAL, CREMATION, REMOVAL Cremation	23b DATE 2-15-85	23c NAME OF CEMETERY OR CREMATORY Security Process		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24 FUNERAL DIRECTOR NAME MacNabb F.H.		ADDRESS Catonsville, Md. 21228		25a DATE REC'D. BY REGISTRAR FEE 8.25 1985	

MEDICAL CERTIFICATION

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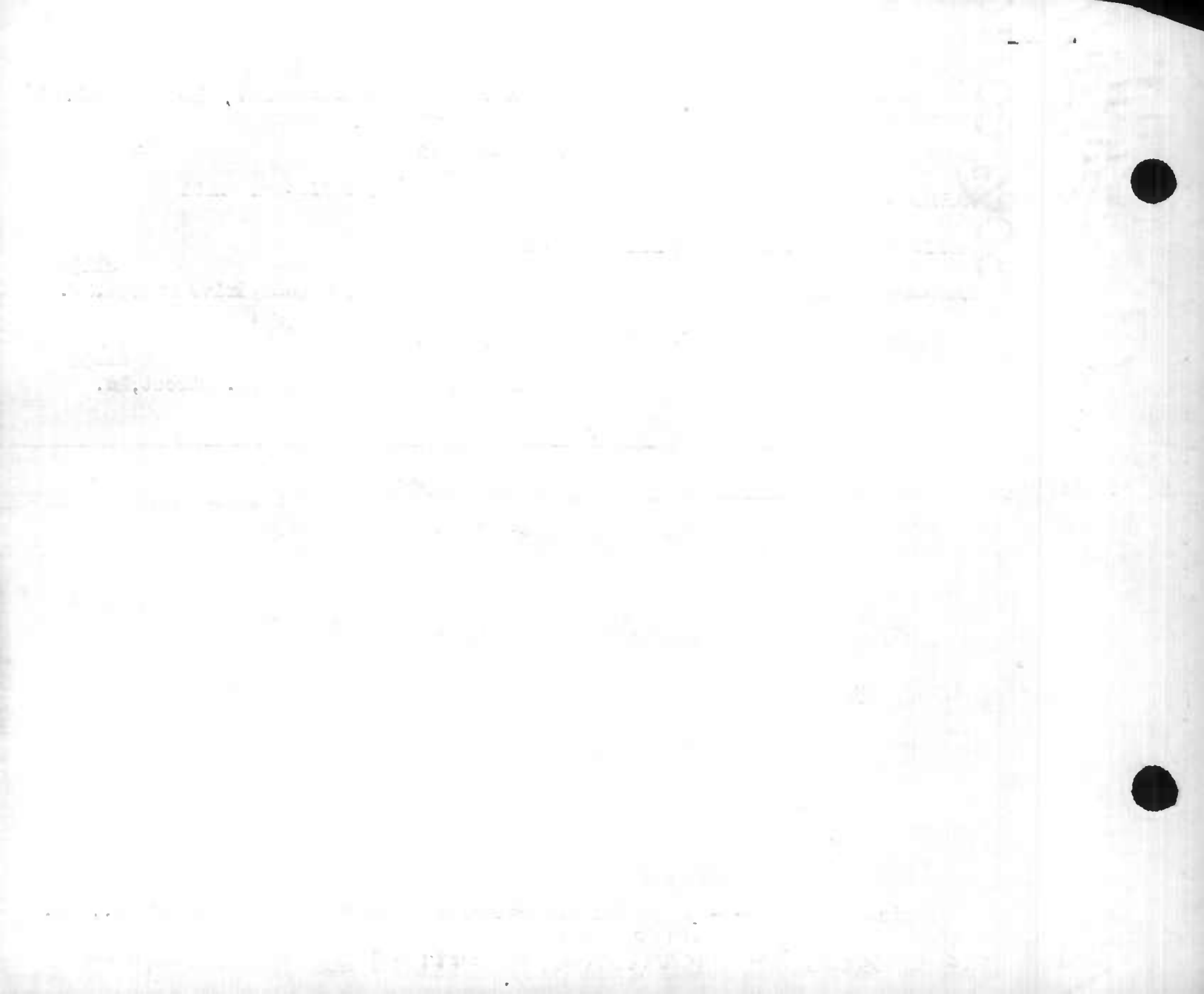
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 2 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JEREMY		2a. DATE OF DEATH MONTH FEBRUARY DAY 7 YEAR 1985	
3 SEX MALE		2b. HOUR 12:31 P M	
4 RACE WHITE		6. AGE (IN YEARS LAST BIRTHDAY) MONTH 1 DAY 22 YEAR 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. IF UNDER 1 YEAR MONTHS 16 DAYS 16 HOURS 16 MIN.	
7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. STREET ADDRESS / ZIP CODE 3238 Lucky Drive Street, Md. 21154	
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Henry MIDDLE Jones LAST Jones		15. MOTHER'S MAIDEN NAME FIRST Michele MIDDLE Nay LAST Nay	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS 3238 Lucky Dr. Street, Md. 21154		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) low CARDIAC OUTPUT (b) CONGESTIVE HEART FAILURE (c) HYPERTENSIVE LEFT VENTRICULAR AND TRUNCUS ARTERIOSIS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (b) (c)			
19a. DATE OF OPERATION 2/7/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CONGESTIVE HEART FAILURE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M.	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/6 19 85 to 2/7 19 85 , that (I) (we) lost saw the deceased alive on 2/7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE G. J. MAGOVARN DEGREE		22c. DATE SIGNED 2/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAGOVARN, George		22e. ADDRESS JOHNS HOPKINS HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-9-85	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Co., Md.	
24. FUNERAL DIRECTOR NAME E.F. LASSAHL F.H. ADDRESS 11750 Bel Air Rd. Kingville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 11 1985	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lucy Neal</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>February 3, 1985</i>		2b. HOUR <i>5:15 P</i>	
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 13 49</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Md Gen Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3300 Benson Ave 21224</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederic Smith</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Raker</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Maria Boyer 1134 Woodway Ave</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Cancer of Esophagus (Carcinoma)</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>February 2, 1985</i> , to <i>February 3, 1985</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>February 3, 1985</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Muhammad Aslam</i> DEGREE <i>M.D.</i>				22c. DATE SIGNED <i>2-3-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Muhammad Aslam, M.D.</i>				22e. ADDRESS <i>c/o Maryland General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/5/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Muhammad Aslam 6350 Gilman St</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 6 1985</i>		25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>	

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DAVID

REBBIE MOTT

WILL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04630

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JACOB			2a. DATE OF DEATH MONTH DAY YEAR 2 17 85			2b. HOUR 11:45 M		
3. SEX M ALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 15 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCCER		12b. KIND OF BUSINESS OR INDUSTRY FOODS	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHAIM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HINDA		13e. STREET ADDRESS / ZIP CODE 5612 JONQUIL AVE. #21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 217-22-1058		17. INFORMANT MRS. ANNE NEEDLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) UROSEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE VCDALY		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/17/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VCDALY, MD		22e. ADDRESS SINAI HOSPITAL, BALTIMORE, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25a. DATE REC'D. BY REGISTRAR FEB 20 1985				
6010 REISTERSTOWN RD. BALTO., MD 21215				25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04631

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AUGUSTA S. NEISTADT			2a. DATE OF DEATH MONTH DAY YEAR 02-28-85		2b. HOUR 1:15 PM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 5, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME FOR THE AGED		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST	12b. KIND OF BUSINESS OR INDUSTRY DRUGS	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21215
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC SOLODAR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LANGE		16. SOCIAL SECURITY NO. 577-05-3242	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT LOUIS KAPLAN		ADDRESS 3620 C FORDS LANE (21215)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GANGRENE, RT FOOT DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC P.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MTHS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (i)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-26 , 19 85 , to 2-28 , 19 85 , that (I) (we) last saw the deceased alive on 2-28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. ZAW-WIN, MD		DEGREE BALTO		22c. DATE SIGNED 2-28-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-WIN, MD		22e. ADDRESS LEVINDALE GERIATRIC CTR 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-1-85	23c. NAME OF CEMETERY OR CREMATORY WORKMENS CIRCLE CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required by the State of Maryland is 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then the funeral director should complete Pages 1 and 2 should be filled within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The funeral director must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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1001010
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 3 2

1- FOR
STATE
REGISTRAR OPAL NEUMANN

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Opal Neumann</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 17 85</i>		2b. HOUR <i>5:45 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 27, 1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Oklahoma</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <i>100 S. Prospect Avenue 21228</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hugh Cozart</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Verna Burford</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>322-48-4248</i>		17. INFORMANT ADDRESS <i>4213 Vermont Avenue LaNell Schultheis Baltimore, Md. 21229</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>End Stage Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic Myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>LE C.V.D.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if (this hospital) attended the deceased from <i>2/11/85</i> 19 <i>85</i> to <i>2/17</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Amars</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2-18-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABAIL P. IMAM</i>				22e. ADDRESS <i>St. Agnes Hospital, Baltimore, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/21/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Granite Lutheran Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Greer Oklahoma</i>	
24. FUNERAL DIRECTOR <i>Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 19 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Richardson-Randell</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is signed, any injury, or other traumatic event, medical examiner's office must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR William August Neumann		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE) William August Neumann			2a. DATE OF DEATH MONTH Feb. DAY 24 YEAR 85		2b. HOUR 7:15 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 9 DAY 30 YEAR 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes 900 S. Caton Ave		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City	
12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Plumber		13. STREET ADDRESS / ZIP CODE 14975 Old Frederick Rd. Woodbine Md. 21797	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 14975 Old Frederick Rd. Woodbine Md. 21797		13c. STREET ADDRESS / ZIP CODE 14975 Old Frederick Rd. Woodbine Md. 21797	
14. FATHER'S NAME FIRST Joseph MIDDLE Howard LAST Woodbine		15. MOTHER'S MAIDEN NAME FIRST Matilda MIDDLE Glaser LAST Glaser		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16a. SOCIAL SECURITY NO. 212-32-1650		17. INFORMANT Mrs. Wm. Neumann Same as 13e.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis - Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thromboses DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John P Lavery		DEGREE MD		22c. DATE SIGNED 2/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P LAVERY		22e. ADDRESS St Agnes Hospital Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/85		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Violetville Md.		24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave. Catonsville, Md. 21228 ADDRESS Leroy M. & Russell C. Witzke Funeral Home			
25. DATE RECEIVED BY REGISTRAR FEB 26 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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3. 2. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 8

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANNA ROSE NEUSCHAFER
<i>ANNA ROSE NEUSCHAFER</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 / 22 / 85 | | 2b. HOUR
8 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 10 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mason F. Lord Nursing H. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
620 N. Kenwood Ave. 21205 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick Lindhurst | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Kotrla | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
214-03-20730 | 17. INFORMANT ADDRESS
Mollie Mayr (dghtr) 7231 Conley St. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis - ? influenza
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Dementia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Dementia Anemia Agostemia UTI'S | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 83 , to 2/22 , 19 85 , that (I) (we) lost
saw the deceased alive on 2/22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Reha Wuthamer</i> MD | | DEGREE
MD | | 22c. DATE SIGNED
2/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/25/85 | 23c. NAME OF CEMETERY OR CREMATORY
Bohemian Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Schia Davidson-Randall</i> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FEB 2 1963

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RECEIVED
FEB 2 1963

[Faint, illegible handwriting and bleed-through from the reverse side of the page are visible throughout the document.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARCELLA Nicholson | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 20 85 | | 2b. HOUR
7:30 AM | | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 11 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Ctr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2021 Robb Street 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Cornish | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marcella Aquilla | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | 16b. SOCIAL SECURITY NO.
212-74-3021 | | 17. INFORMANT
ADDRESS
Elsie Richard 2021 Robb Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) influenza
DUE TO, OR AS A CONSEQUENCE OF (c) BCVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (u) (this hospital) attended the deceased from 1/15 , 19 85 , to 2/20 , 19 85 , that (l) (we) lost 2/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (l) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Debra Swartzman MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/20/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DEBRA SWARTZMAN | | | 22e. ADDRESS
5200 EASTERN AVE | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. National Mem Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| ADDRESS
1101 E North Avenue | | | | | | | | | | | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 3 6

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|---|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Charles J. Nocar | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-19-85 | | 2b. HOUR
04:00 A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 2 10 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
74 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS.
HOURS MIN.
04:00 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
DuPont Chemical | | 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | |
| 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Ferndale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
26 4th Avenue 21061 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
John Nocar | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Venecek | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-10-6560 | | 17. INFORMANT
ADDRESS
Helen D. Nocar Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC + RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PANCREATIC ISLET CELL TUMOR
DUE TO, OR AS A CONSEQUENCE OF (c) 10 YRS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
James E. Taylor | | DEGREE
M.D. | | 22c. DATE SIGNED
2/19/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. TAYLOR, M.D. | | 22e. ADDRESS
ST. AGNES HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore A.A. Md | | 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Fendell | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|-------------------|--|----------------|--|---------------|--|-------|--|-------|--|
| Name | | Address | | City | | State | | Zip | |
| Mr. J. H. Smith | | 123 Main St. | | New York | | NY | | 10001 | |
| Mrs. A. B. Jones | | 456 Elm St. | | Los Angeles | | CA | | 90001 | |
| Mr. C. D. Brown | | 789 Oak St. | | Chicago | | IL | | 60601 | |
| Ms. E. F. Green | | 101 Pine St. | | Houston | | TX | | 77001 | |
| Mr. G. H. White | | 202 Cedar St. | | Phoenix | | AZ | | 85001 | |
| Mrs. I. J. Black | | 303 Birch St. | | San Antonio | | TX | | 78201 | |
| Mr. K. L. Gray | | 404 Maple St. | | Dallas | | TX | | 75201 | |
| Ms. M. N. Hall | | 505 Elm St. | | Austin | | TX | | 78701 | |
| Mr. O. P. King | | 606 Oak St. | | Fort Worth | | TX | | 76101 | |
| Mrs. Q. R. Lee | | 707 Pine St. | | San Diego | | CA | | 92101 | |
| Mr. S. T. Scott | | 808 Cedar St. | | San Jose | | CA | | 95101 | |
| Ms. U. V. Walker | | 909 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. W. X. Young | | 1010 Maple St. | | Seattle | | WA | | 98101 | |
| Mrs. Y. Z. Adams | | 1111 Elm St. | | Portland | | OR | | 97201 | |
| Mr. A. B. Baker | | 1212 Oak St. | | Denver | | CO | | 80201 | |
| Ms. C. D. Carter | | 1313 Pine St. | | Boston | | MA | | 02101 | |
| Mr. E. F. Evans | | 1414 Cedar St. | | Philadelphia | | PA | | 19101 | |
| Mrs. G. H. Fisher | | 1515 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. I. J. Gibson | | 1616 Maple St. | | New York | | NY | | 10001 | |
| Ms. K. L. Hall | | 1717 Elm St. | | Los Angeles | | CA | | 90001 | |
| Mr. M. N. Hill | | 1818 Oak St. | | Chicago | | IL | | 60601 | |
| Mrs. O. P. King | | 1919 Pine St. | | Houston | | TX | | 77001 | |
| Mr. Q. R. Lee | | 2020 Cedar St. | | Phoenix | | AZ | | 85001 | |
| Ms. S. T. Scott | | 2121 Birch St. | | San Antonio | | TX | | 78201 | |
| Mr. U. V. Walker | | 2222 Maple St. | | Dallas | | TX | | 75201 | |
| Mrs. W. X. Young | | 2323 Elm St. | | Austin | | TX | | 78701 | |
| Mr. Y. Z. Adams | | 2424 Oak St. | | Fort Worth | | TX | | 76101 | |
| Ms. A. B. Baker | | 2525 Pine St. | | San Diego | | CA | | 92101 | |
| Mr. C. D. Carter | | 2626 Cedar St. | | San Jose | | CA | | 95101 | |
| Mrs. E. F. Evans | | 2727 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. G. H. Fisher | | 2828 Maple St. | | Seattle | | WA | | 98101 | |
| Ms. I. J. Gibson | | 2929 Elm St. | | Portland | | OR | | 97201 | |
| Mr. K. L. Hall | | 3030 Oak St. | | Denver | | CO | | 80201 | |
| Mrs. M. N. Hill | | 3131 Pine St. | | Boston | | MA | | 02101 | |
| Mr. O. P. King | | 3232 Cedar St. | | Philadelphia | | PA | | 19101 | |
| Ms. Q. R. Lee | | 3333 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. S. T. Scott | | 3434 Maple St. | | New York | | NY | | 10001 | |
| Mrs. U. V. Walker | | 3535 Elm St. | | Los Angeles | | CA | | 90001 | |
| Mr. W. X. Young | | 3636 Oak St. | | Chicago | | IL | | 60601 | |
| Ms. Y. Z. Adams | | 3737 Pine St. | | Houston | | TX | | 77001 | |
| Mr. A. B. Baker | | 3838 Cedar St. | | Phoenix | | AZ | | 85001 | |
| Mrs. C. D. Carter | | 3939 Birch St. | | San Antonio | | TX | | 78201 | |
| Mr. E. F. Evans | | 4040 Maple St. | | Dallas | | TX | | 75201 | |
| Ms. G. H. Fisher | | 4141 Elm St. | | Austin | | TX | | 78701 | |
| Mr. I. J. Gibson | | 4242 Oak St. | | Fort Worth | | TX | | 76101 | |
| Mrs. K. L. Hall | | 4343 Pine St. | | San Diego | | CA | | 92101 | |
| Mr. M. N. Hill | | 4444 Cedar St. | | San Jose | | CA | | 95101 | |
| Ms. O. P. King | | 4545 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. Q. R. Lee | | 4646 Maple St. | | Seattle | | WA | | 98101 | |
| Mrs. S. T. Scott | | 4747 Elm St. | | Portland | | OR | | 97201 | |
| Mr. U. V. Walker | | 4848 Oak St. | | Denver | | CO | | 80201 | |
| Ms. W. X. Young | | 4949 Pine St. | | Boston | | MA | | 02101 | |
| Mr. Y. Z. Adams | | 5050 Cedar St. | | Philadelphia | | PA | | 19101 | |
| Mrs. A. B. Baker | | 5151 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. C. D. Carter | | 5252 Maple St. | | New York | | NY | | 10001 | |
| Ms. E. F. Evans | | 5353 Elm St. | | Los Angeles | | CA | | 90001 | |
| Mr. G. H. Fisher | | 5454 Oak St. | | Chicago | | IL | | 60601 | |
| Mrs. I. J. Gibson | | 5555 Pine St. | | Houston | | TX | | 77001 | |
| Mr. K. L. Hall | | 5656 Cedar St. | | Phoenix | | AZ | | 85001 | |
| Ms. M. N. Hill | | 5757 Birch St. | | San Antonio | | TX | | 78201 | |
| Mr. O. P. King | | 5858 Maple St. | | Dallas | | TX | | 75201 | |
| Mrs. Q. R. Lee | | 5959 Elm St. | | Austin | | TX | | 78701 | |
| Mr. S. T. Scott | | 6060 Oak St. | | Fort Worth | | TX | | 76101 | |
| Ms. U. V. Walker | | 6161 Pine St. | | San Diego | | CA | | 92101 | |
| Mr. W. X. Young | | 6262 Cedar St. | | San Jose | | CA | | 95101 | |
| Mrs. Y. Z. Adams | | 6363 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. A. B. Baker | | 6464 Maple St. | | Seattle | | WA | | 98101 | |
| Ms. C. D. Carter | | 6565 Elm St. | | Portland | | OR | | 97201 | |
| Mr. E. F. Evans | | 6666 Oak St. | | Denver | | CO | | 80201 | |
| Mrs. G. H. Fisher | | 6767 Pine St. | | Boston | | MA | | 02101 | |
| Mr. I. J. Gibson | | 6868 Cedar St. | | Philadelphia | | PA | | 19101 | |
| Ms. K. L. Hall | | 6969 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. M. N. Hill | | 7070 Maple St. | | New York | | NY | | 10001 | |
| Mrs. O. P. King | | 7171 Elm St. | | Los Angeles | | CA | | 90001 | |
| Mr. Q. R. Lee | | 7272 Oak St. | | Chicago | | IL | | 60601 | |
| Ms. S. T. Scott | | 7373 Pine St. | | Houston | | TX | | 77001 | |
| Mr. U. V. Walker | | 7474 Cedar St. | | Phoenix | | AZ | | 85001 | |
| Mrs. W. X. Young | | 7575 Birch St. | | San Antonio | | TX | | 78201 | |
| Mr. Y. Z. Adams | | 7676 Maple St. | | Dallas | | TX | | 75201 | |
| Ms. A. B. Baker | | 7777 Elm St. | | Austin | | TX | | 78701 | |
| Mr. C. D. Carter | | 7878 Oak St. | | Fort Worth | | TX | | 76101 | |
| Mrs. E. F. Evans | | 7979 Pine St. | | San Diego | | CA | | 92101 | |
| Mr. G. H. Fisher | | 8080 Cedar St. | | San Jose | | CA | | 95101 | |
| Ms. I. J. Gibson | | 8181 Birch St. | | San Francisco | | CA | | 94101 | |
| Mr. K. L. Hall | | 8282 Maple St. | | Seattle | | WA | | 98101 | |
| Mrs. M. N. Hill | | 8383 Elm St. | | Portland | | OR | | 97201 | |
| Mr. O. P. King | | 8484 Oak St. | | Denver | | CO | | 80201 | |
| Ms. Q. R. Lee | | 8585 Pine St. | | Boston | | MA | | 02101 | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504637

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|---|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Blanch</u> <u>NORRIS</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>2</u> <u>12</u> <u>85</u> | | 2b. HOUR
<u>10 45 AM</u> | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Cauc.</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>11</u> <u>6</u> <u>10</u> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<u>74</u> YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 8. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>So. Balt. Gen. Hosp</u> | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOME MAKER</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | | 13a. STREET ADDRESS / ZIP CODE
<u>10 Victory St. 21001</u> | | |
| 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. CITY OR TOWN
<u>ABERDEEN</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Elleck</u> <u>Johnson</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Emma</u> <u>Snider</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<u>No</u> | | |
| 16b. SOCIAL SECURITY NO.
<u>213-26-8050</u> | | 17. INFORMANT
<u>SHAFFER NORRIS, 10 Victory St., ABERDEEN, MD, 21001</u> | | ADDRESS | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCD

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 <u>85</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>85</u> , to <u>2/12</u> , 19 <u>85</u> , that (I) (we) last
saw the deceased alive on <u>2/12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/12/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Harold E. Hynd</u> | | 22e. ADDRESS
<u>3001 S. Hanover St. Balt. 21230</u> | | | | | |

| | | | | | | | |
|---|--|--------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>REMOVAL/BURIAL</u> | | 23b. DATE
<u>15 FEB. 85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>RUDY BRANCH CEMETERY</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BRISTOL-SULLIVAN - TENN.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>TARRING FUNERAL HOME, P.A., ABERDEEN, MD, 21001-3399</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 19 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

1

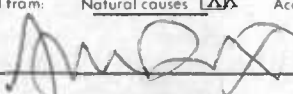
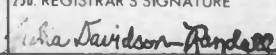
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the purchase of land for the purpose of establishing a new settlement for the benefit of the Indians of the reservation at Fort Snelling, Minnesota.

I am sorry to hear that the land is not available for the purpose intended. I have, however, endeavored to secure the same, and I am confident that it will be made available in the near future. I am, Sir, very respectfully,
Yours very truly,
J. M. Smith

Very truly,
J. M. Smith
Special Agent in Charge
Bureau of Indian Affairs
Washington, D.C.

10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 5 0 4 6 3 8 | |
|--|------------------|--|------------------------------|---|---|---|--|---|--|--|--|
| 1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Marie (Mary) A. Novotny | | | | | | | | | | 2a. DATE KNOWN OF DEATH
XX 2 26 19 85 | |
| 1. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Feb. 16, 1916 | 6. AGE (IN YEARS)
69 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD
2 26 19 85 | | 2d. HOUR
4:45 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1304 Sherwood Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1304 Sherwood Avenue 21239 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Buckmeier | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
218-54-2785 | | 17. INFORMANT
ADDRESS
Crofton, Md. 21114
Mr. Joseph H. Novotny 1723 Stratton Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2/27/85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. Balto, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Mar. 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 28 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

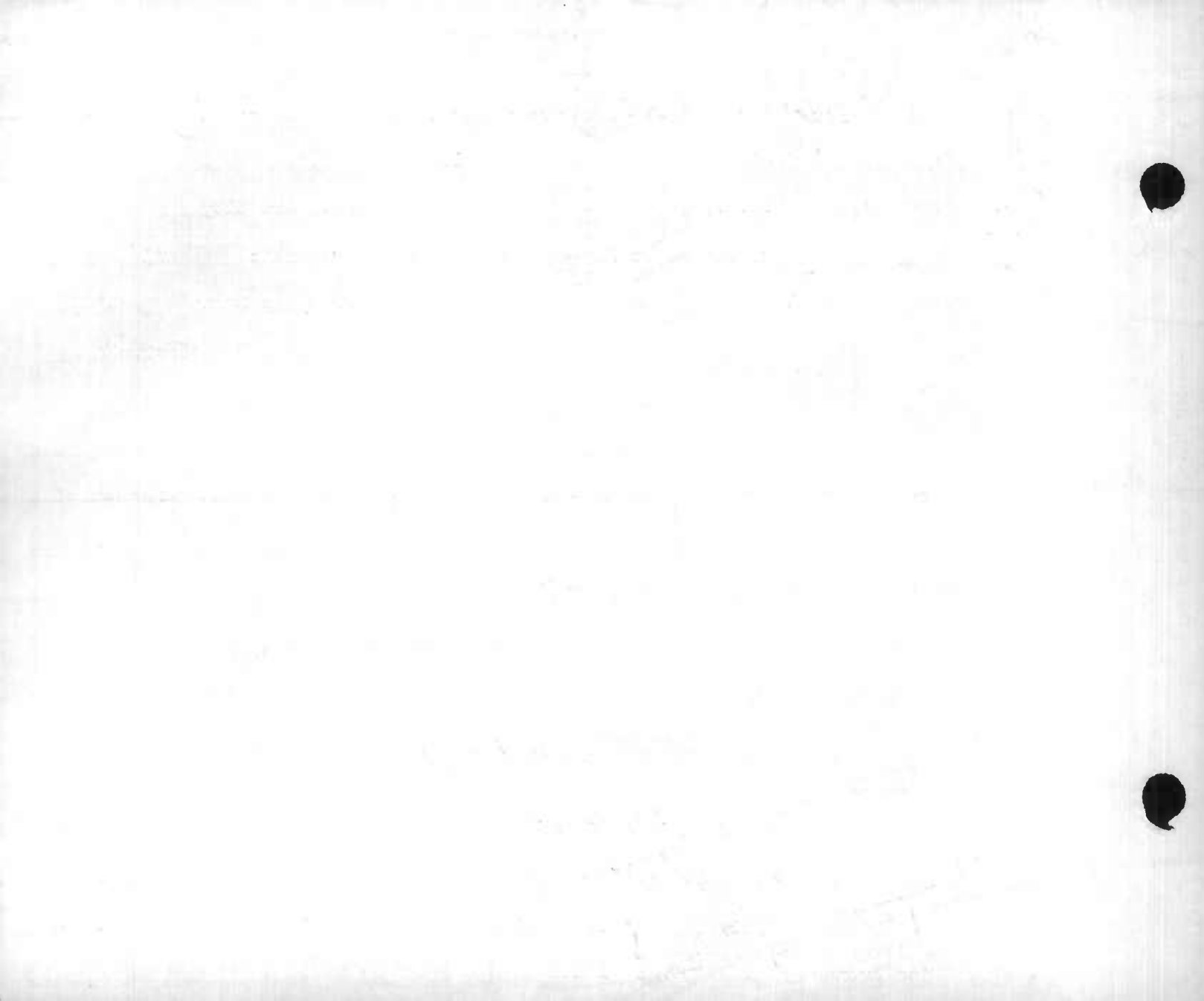
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 3 9

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bertha ROSE Nukolczak | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 9 85 | | | 2b. HOUR
10 37 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 22 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
Tailor Shop | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
803 Glass Avenue 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Kulik | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Zasowska | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
215-14-5920 | | 17. INFORMANT
Elmer G. Nukolczak | | | | ADDRESS
Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus, CRF, HTN
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-26-85 19 85 , to 2-9 19 85 , that (I) (we) lost saw the deceased alive on 2-9 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Charles Wendt MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-9-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles Wendt | | | 22e. ADDRESS
Francis Scott Key Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/13/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck, Inc. ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE
FEB 13 1985 <i>[Signature]</i> | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504640

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM R. O'BRIEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 85 | | 2b. HOUR
2:50A M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 24 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, BALTIMORE, MD. 21218 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Construction Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Ellicott City, Md. |
| 13a. STATE
Md. | 13b. CITY OR TOWN
Ellicott City | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
3256A Normandy Wood Dr. #21043 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas E. O'Brien, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie M. Warner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes-Oct. '41-Nov. '45 | | 16b. SOCIAL SECURITY NO.
216-05-3843 | | 17. INFORMANT
Thomas E. O'Brien, Jr. City, Md. #21043 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Extensive head and neck carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/5, 1985, to 2/13, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/13, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Scott A. Braghi</u> | | DEGREE | | 22c. DATE SIGNED
2/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott A. Braghi MD | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 16, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 23e. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
G. Truman Schwab | | 3512 Frederick Ave.
ADDRESS
21229 | | 25b. REGISTRAR'S SIGNATURE
<u>Richardson-Randall</u> | |

30% COTTON LINES

CHIEF MANAGER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04641

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROY E. O'CONNOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 10 85 | | | 2b. HOUR
240 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 4 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TEXAS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED. CEN. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MARITIME | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
11 S. LINWOOD AVE. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
21307 6274 | | 17. INFORMANT
ADDRESS
MARY O'CONNOR 11 S. LINWOOD AVE. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Resp failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **CHF, Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 85 , to 2/10 , 19 85 , that (I) (we) last saw the deceased alive on 2/10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Rob Goldberg | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROB GOLDBERG | | | | 22e. ADDRESS
6062 E. Pratt St Balto, Md | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | 23b. DATE
2-13-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART JESUS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Raymond L. Kaczorowski 2525 Fleet St. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a certain time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

LIBRARY

20%

DOWN

UP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM DELPHEY O'CONNOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 85 | | 2b. HOUR
7:30 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 4, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk - Stieff | | 12b. KIND OF BUSINESS OR INDUSTRY
Silver Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. COUNTY | 13d. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS / ZIP CODE
4630 Elsrade Ave., 21214 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William O'Connor | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Kate Delphey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219 01 4028 | 17. INFORMANT
ADDRESS
Mrs. Esther M. Moore, Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary tract Sepsis</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Atherosclerotic vascular disease</u> | | | | | |
| 19a. DATE OF OPERATION
- | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>85</u> , to <u>2/10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Betty A. Fay</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/10/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BETTY A. FAY | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/13/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mount View | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Union Bridge, MD | | |
| 24. FUNERAL DIRECTOR
NAME Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>Davidson-Randall</u> | | |

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MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 3

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHRISTOPHER OGLE SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11, 1985 | | 2b. HOUR
9:50^{PM} |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 21 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Corp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY
City of Balto. | |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
531 N. Rose St. 21205 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Ogle | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Strohecker | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Ruby Ogle (wife) same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) RUPTURED AORTIC ANEURYSM
(c) AORTO -BI-FEMEROL BYPASS (2/8) LEFT FEMEROL POPITEAL BYPASS (2/8) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
1) CARDIAC ARRYTHMIA 2) PULMONARY FAILURE | | | | | |
| 19a. DATE OF OPERATION
FEBRUARY 8 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AORTIC ANEURYSM LEFT FEMEROL POPITEAL BYPASS | | 20. AUTOPSY?
NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 29, 1985 to FEBRUARY 11, 1985 , that (I) (we) lost
saw the deceased alive on FEBRUARY 11, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>SK Prasad Sompalli</i> | | DEGREE
PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SK PRASAD SOMPALLI M.D. | | 22e. ADDRESS
100 NORTH BROADWAY 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>J. Davidson-Randall</i> | |
| 25c. ADDRESS
3331 Brehms Lane, Balto. Md. 21213 | | | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|-------------------------|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BLANCHE ABI OPAL | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 2-5-85 19 | | 2b. HOUR pm | | 2c. DATE OF DEATH
ESTIMATED <input type="checkbox"/> 2-5-85 19 | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR April 17, 1901 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS. 83 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 8. IF UNDER 24 HRS.
HOURS MIN | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital - 21202 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housemother-childrens' home | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Rtd | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James R. Heflin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah L. Butler | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. OCCUPATION NO.
213-12-4081 | |
| 17. INFORMANT
Ralph M. Murdy, Esq. | | | | 17. ADDRESS
5718 Harford Rd. - | | | | 17. CITY OR TOWN
Baltimore | | | | 17. STATE
Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
Feb. 7, 1985 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematorium | | | | | |
| 23d. LOCATION
CITY OR TOWN COUNTY
Balto. City, Md. | | | | 23e. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | | | 23f. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry Sander & Sons, Inc., Balto., Md. | | | | | | 24. ADDRESS
21213 | | | | | | | |

ROY COLTON LIPES

WILKINSON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 5

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|---------------|---|--|--|-----------|------------------|---------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
JOSEPH | | MIDDLE
MONROE | LAST
OPHER | 2a. DATE OF DEATH | | MONTH
2 | DAY
18 | YEAR
85 | 2b. HOUR
M |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH
10
DAY
4
YEAR
24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60
YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MADISON, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4704 SPRINGDALE AVE. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
TOWSON STATE | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4704 SPRINGDALE AVE. 21207 | | | |
| 14. FATHER'S NAME
FIRST
JOSEPH | | MIDDLE | | LAST
KEENE | | 15. MOTHER'S MAIDEN NAME
FIRST
IDA | | MIDDLE | | LAST
OPHER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO YES | | 16b. SOCIAL SECURITY NO.
216-18-2296 | | 17. INFORMANT
MAE OLA OPPER | | ADDRESS
4704 SPRINGDALE AVE. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Squamous Carcinoma of RI Lung, RECURRENT</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 mos. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov.</i> 19 <i>83</i> , to <i>FEB.</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2-13</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Harold E. Ramsey, M.D.</i> | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-19-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD E. RAMSEY | | 22e. ADDRESS
301 McMECHEN ST. BALTIMORE, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION
(CITY OR TOWN)
BALTIMORE | | COUNTY
MD | | STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT | | ADDRESS
4600 LIBERTY HGTS. AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Frederick Randall</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COTTON

CHIEF MAN

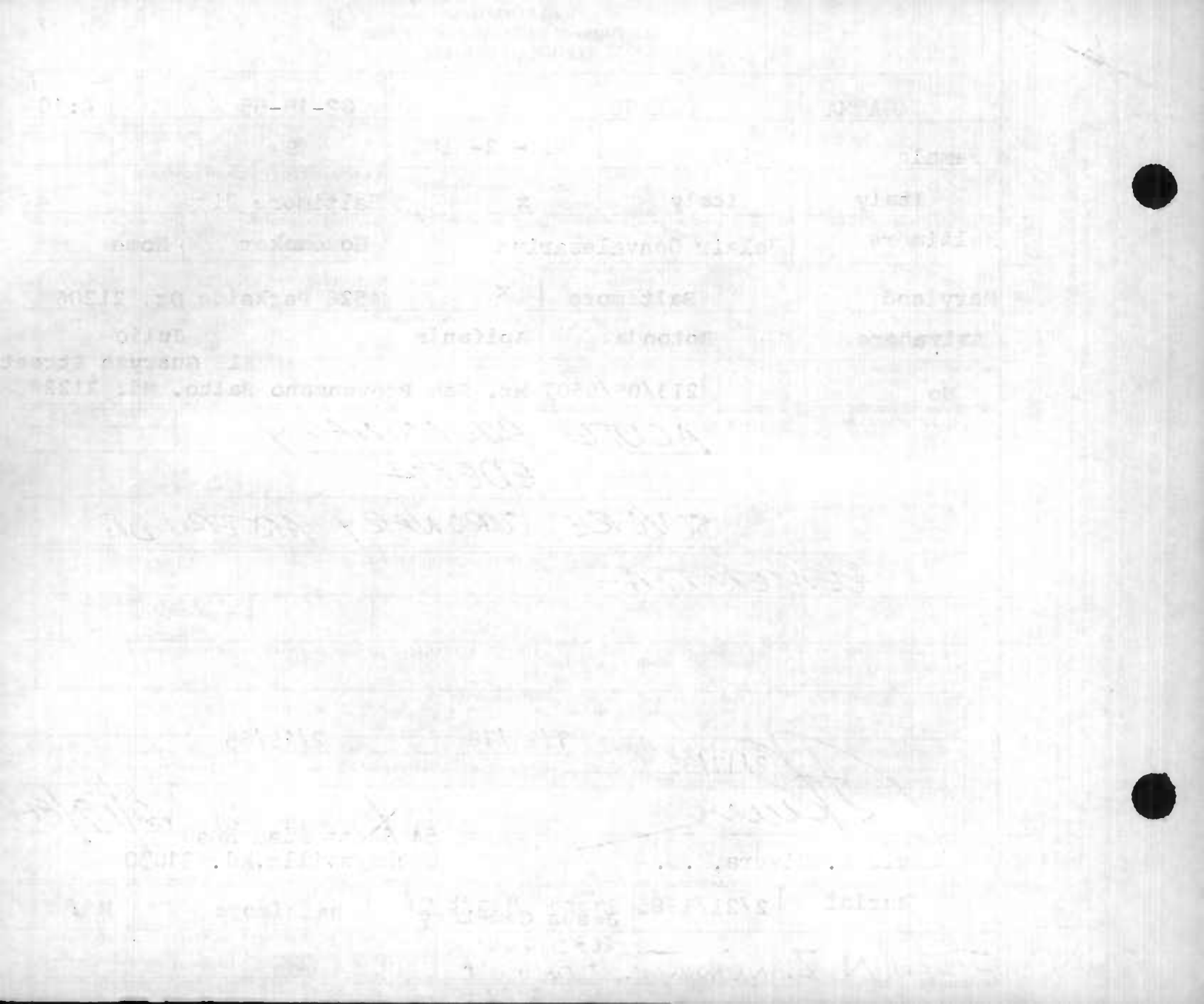


1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--------------------------------|--|-------|--|------|--|----------|--|-----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | A | |
| AGATHA | | | | ORLANDO | | | | 02-19-85 | | | | | | | | 4:10M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | | | | | | | |
| Female | | White | | 11 - 2 - 1885 | | 99 | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Italy | | Italy | | | | Baltimore City | | | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | Belair Convalesarium | | Homemaker | | Home | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4526 Parkside Dr. 21206 | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | | | | | | | | | | | | |
| Salvatore | | | | Rotonda | | | | Apifania | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 213/05/9507 | | Mr. Sam Provenzano Balto. Md. 21224 | | 319 Gusryan Street | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| ACUTE PULMONARY | | EDEMA | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | | | |
| SEVERE CORONARY ARTERY DIS. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | DEMENTIA | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7/21/78 19 to 2/19/85 19 that (1) (we) last saw the deceased alive on 2/17/85 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (and) (the) (us) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | | | |
| Luis E. Rivera, M.D. | | | | 54 Scott Adam Road Cockeysville, Md. 21030 | | 2/19/85 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CIRCLE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| Burial | | 2/21/1985 | | Sacred Heart of Jesus Cemetery | | Baltimore Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Joseph N. Zannino Jr. | | 263 S. Cowling St. Balto. Md. | | FEB 21 1985 | | Julia Davidson-Randell | | | | | | | | | | | | | |



B

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Elizabeth H Outsler | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 17 85 | | | 2b. HOUR 3:50 P | | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH
MONTH DAY YEAR 9 17 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA-MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Gardens Convalescent Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3103 Mary Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Philip Hofstetter | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Anna Dienstbier | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | |
| 16b. SOCIAL SECURITY NO. 219 189854 | | | 17. INFORMANT ADDRESS 4706 Harford Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Possible Pulmonary Embolism | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Heart Disease | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-11 19 84 , to 2-17 19 85 , that (I) (we) last saw the deceased alive on 2-13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Donato A. Vasquez, Jr. | | | | | | DEGREE MD | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONATO A. VASQUEZ, JR. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22e. ADDRESS 4706 Harford Rd. Balto. MD 21214. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE FEB 21 1985 | | 23c. NAME OF CEMETERY OR CREMATORY New CATHEDRAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME EVANS CHAPL OF MEMORIES | | | ADDRESS 8800 HARFORD ROAD | | | 25a. DATE REC'D. BY REGISTRAR FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE John A. Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



CHIEFMAN

20% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 8

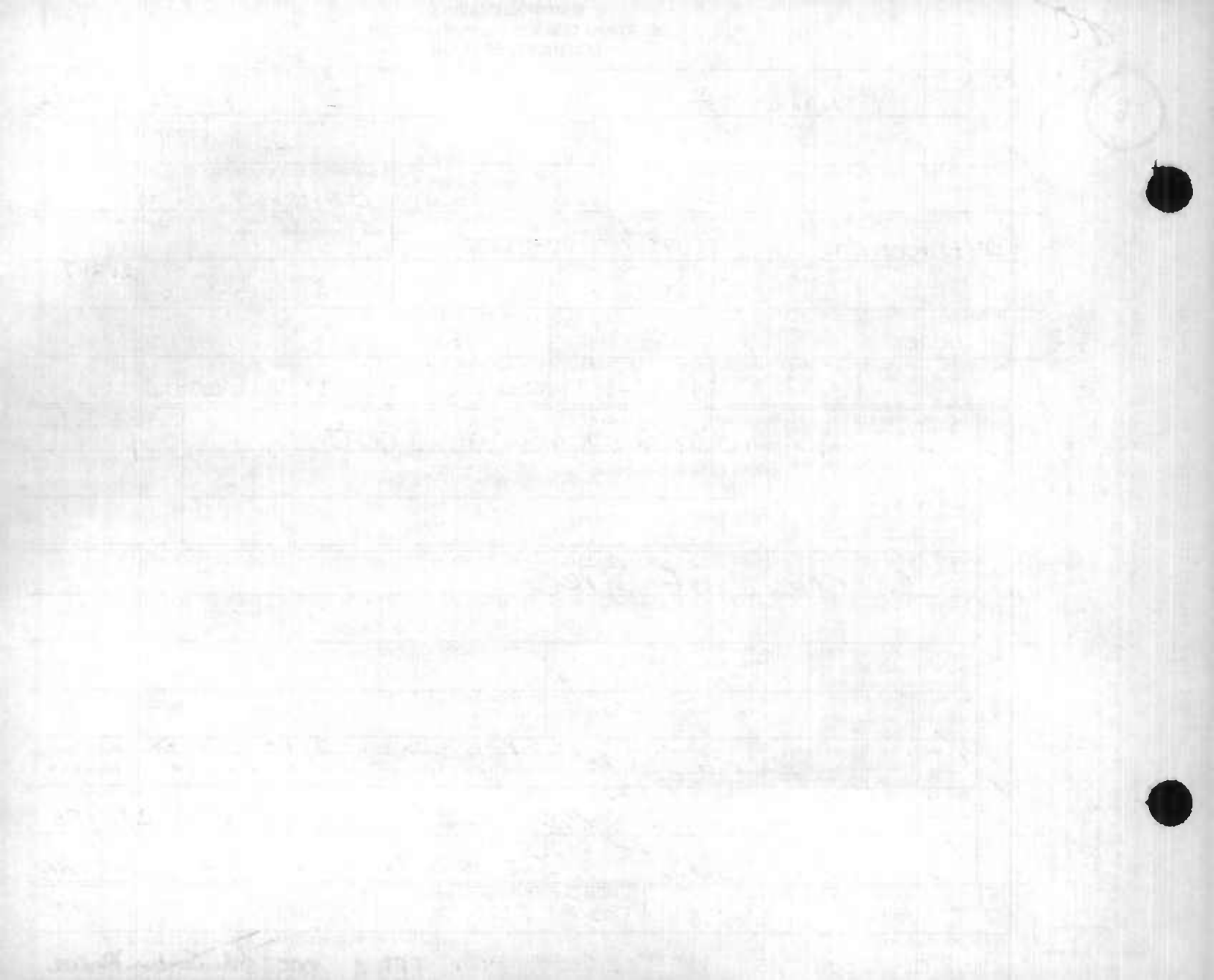
1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Howard A OWENS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 1 85 | | | 2b. HOUR
3:43 AM | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 17 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
71 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2218 Bryant Ave. 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Moses Owens | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pinky Bass | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
244-12-3673 | | 17. INFORMANT
ADDRESS
Charlie Owens 1418 Dukeland St. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cirrhosis of Liver | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 85 , to 2/1 , 19 85 , that (I) (we) last saw the deceased alive on 2-1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. SIGNATURE
David Gandy | | | | | 23b. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 23c. DATE SIGNED
2/1/85 | | |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)
David Gandy | | | | | 23e. ADDRESS
2900 Liberty Heights Ave Balt MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
2/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Chapel Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY
Columbia NC | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 4 9

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
PATRICIA L. OWENS | | | 2a DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 27, 1985 | | | 2b HOUR
11:50
M | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 13 64 | | 6. AGE (IN YEARS LAST BIRTHDAY)
20
YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASS. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
PA. | | | 13b. COUNTY
YORK | | 13c. CITY OR TOWN
YORK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
NORMAN E. OWENS | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH A. SOMERS | | | 13e STREET ADDRESS / ZIP CODE
111 HIGHLAND RD. YORK PA. 17403 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
202-58-0288 | | 17 INFORMANT
ADDRESS
NORMAN F. OWENS 111 HIGHLAND RD. YORK, PA. 17403 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 hours | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Graft versus Host Disease | | | | | | | | 3 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Bone marrow transplant | | | | | | | | 5 weeks | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Acute lymphocytic leukemia | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from February 1 19 85 , to February 27 19 85 , that (I) (we) last saw the deceased alive on February 27 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Joseph M Molina MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-28-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph M Molina MD | | | | | | 22e ADDRESS
600 N Wolfe St. Baltimore MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Savior Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
YORK YORK PA. | | |
| 24 FUNERAL DIRECTOR
J. J. Hartenstein New Freedom, Pa. 17335 | | | | | | 25a DATE REC'D. BY REGISTRAR
MAR 04 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | |



U.S. DISTRICT COURT, S.D. N.Y. v. ...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 5 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SIDNEY GODSEY OWENS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 14 85 | | | 2b. HOUR
11:53 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 23 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
7 14 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MD. HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLOTHING CUTTER | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
ARBUTUS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LUTHER G. OWENS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY L. GODSEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
225-07-6247 | | 17. INFORMANT
ADDRESS
GREG FAULKNER P.O. BOX 37; MATHEWS, VA. 23109 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY EMBOLESM
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
CANCER OF BLADDER | | | | | | | | | |
| 19a. DATE OF OPERATION
2/11/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CANCER OF BLADDER WITH DISSEMINATION | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 85 , to 2/14 19 85 , that (I) (we) last saw the deceased alive on 2/14/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not see the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Michael W. Brown | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL W. BROWN | | | | | | 22e. ADDRESS
22 S. GREENE ST. BALTO, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
REMOVAL/BURIAL | | 23b. DATE
02-17-85 | | 23c. NAME OF CEMETERY OR CREMATORY
GWINN'S ISLAND CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GWINN'S ISLAND MATHEWS VA. | | | |
| 24. FUNERAL DIRECTOR
NAME
BALTO., MD. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

8

11-25-8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 5 0 4 6 5 1 | |
|--|--|---|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
STANLEY, GERALD OWENS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 17, 1985 | | 2b. HOUR
12:00a | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 3, 1951 | 6. AGE (IN YEARS LAST BIRTHDAY)
33 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
US of A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
REGINALD OWENS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GLADYS STERLING | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217 54 1868 | | 17. INFORMANT
ADDRESS
MRS. GLADYS SMITH 3408 ROCKWOOD AVE. 21215 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CAUDOPHARYNGEAL ASYST
DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIOMYOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 HOURS
2 YEARS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7 19 85 , to 2/17 19 85 , that (I) (we) lost saw the deceased live on 2/17 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
James E. Greenwald MD PhD | | DEGREE
MD PhD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES GREENWALD | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEMORIAL PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE (BALTO.) MD. |
| 24. FUNERAL DIRECTOR
NAME
LEWIS T. GWYNN | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |
| ADDRESS
4517 PARK HEIGHTS AVENUE | | | | | | |

BP

STATIONARY CARD

33

MARCH 3, 1951

NAME

NAME

X

NO OF

NAME

ADDRESS

8125 S. VA. THUNDERBOLT AVE. 51218

X

PHONE

PHONE

CITY

CITY

CITY

CITY

5125 S. VA. THUNDERBOLT AVE. 51218

5125 S. VA. THUNDERBOLT AVE. 51218

NO.

5/21/52

5125 S. VA. THUNDERBOLT AVE. 51218

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 5 2

| | | | |
|---|--|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Jason W. Pack | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
2/18/85 948 PM | |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2-12-20 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 6. AGE
(IN YEARS LAST BIRTHDAY)
64 YRS. | 8. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1501 N. Dukeland St. Dukeland | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL RESIDENCE
(IF RAISING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALT 13c. CITY OR TOWN BALT | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
12c. KIND OF BUSINESS OR INDUSTRY | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jason Pack | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Gray | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | 16b. SOCIAL SECURITY NO.
220-07-0979 | |
| 17. INFORMANT
ADDRESS
Geraldine Pack 2720 Kinsey Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)
CVA | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK NOT WHILE AT WORK | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES NO | |
| 21a. INJURY OCCURRED | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
DEGREE
22c. DATE SIGNED | |
| 23a. PHYSICIAN'S NAME (Type or Print)
M. March | | 23b. ADDRESS
9051 BART NRT ELLWOOD C | |
| 24. BURIAL, CREMATION, REMOVAL
BURIAL | | 24b. DATE
2/22/85 | |
| 24c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 24d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, MD | |
| 25. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Ave. | | 25b. DATE REC'D BY REGISTRAR
FEB 20 1985 | |
| 25c. REGISTRAR'S SIGNATURE
J. A. Davidson | | | |

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. FOR
STATE
REGISTER

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
NICHOLAS P. PANTELEAKIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 6, 1985 | | 2b. HOUR
10:17pm |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 10, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cook | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Service |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Panteleakis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Angelina Partagmos | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
117-22-9309 | | 17. INFORMANT ADDRESS
Helen N. Panteleakis - Same as #13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
40 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from 2/6 19 85 , to 2/6 19 85 , that (1) (we) last saw the deceased alive on 2/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert Stamp MD
DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2-6-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Stamp | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL Baltimore, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-9-85 | 23c. NAME OF CEMETERY OR CREMATORY
Greek Orthodox | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of the death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, or medical condition, the death certificate must be signed by a physician.

2210

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 5 4

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Parker Elsie T Parker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-5-85 | | | 2b. HOUR
MIN
3:15 P. M. | | | |
| SEX
Female | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 15 19 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
MONTHS DAYS
65 YRS. | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN.
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY
BALTO | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
21216 3130 Gwynns Falls Pkwy | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Dutton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Kane | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Angela D. Parker 2908 Garrison Blvd. | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cancer of the Colon - WITH METASTASIS | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5/85 19 85 to 2/5 19 85 , that (I) (we) lost
saw the deceased alive on 2/5/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMISUENO | | | | 22e. ADDRESS
730 Ashburton St. Baltimore Md | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | |
|--|--|-----------------------------|--|---|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Ave. | | 24b. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | 24c. REGISTRAR'S SIGNATURE
[Signature] | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE V LAST PARKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-6 1985 | | 2b. HOUR
4:52 AM | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BETH SECOURS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13c. CITY OR TOWN
Severna Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
121 Metispa Drive 21146 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William WALKER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY STEWART | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
217-03-2579 | | 17. INFORMANT
ADDRESS
121 Metispa Dr. Severna Park, Md | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>HYPOTENSION, MALNUTRITION, DEHYDRATION -</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RENAL FAILURE</u>
UPPER G.I. BLEEDING | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>URINARY TRACT INFECTION, SEPSIS</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
BONN SECOURS HOSPITAL | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>85</u> to <u>2/6</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> 19 <u>85</u> and that in <u>our</u> opinion death occurred on the date and hour and from the causes stated above. <u>and we did not</u> view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Howard B. Chen</u> | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/6/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD B. CHEN | | 22e. ADDRESS
BON SECOURS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 9, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Hill Chr. Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lusby Calvert Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Spencer E. Sewell Box 31, Prince Frederick, Md | | | | |
| 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 11 1985 Julia Davidson-Rodriguez | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 5 6

FOR
1 - STATE
REGISTRAR

REG. NO.

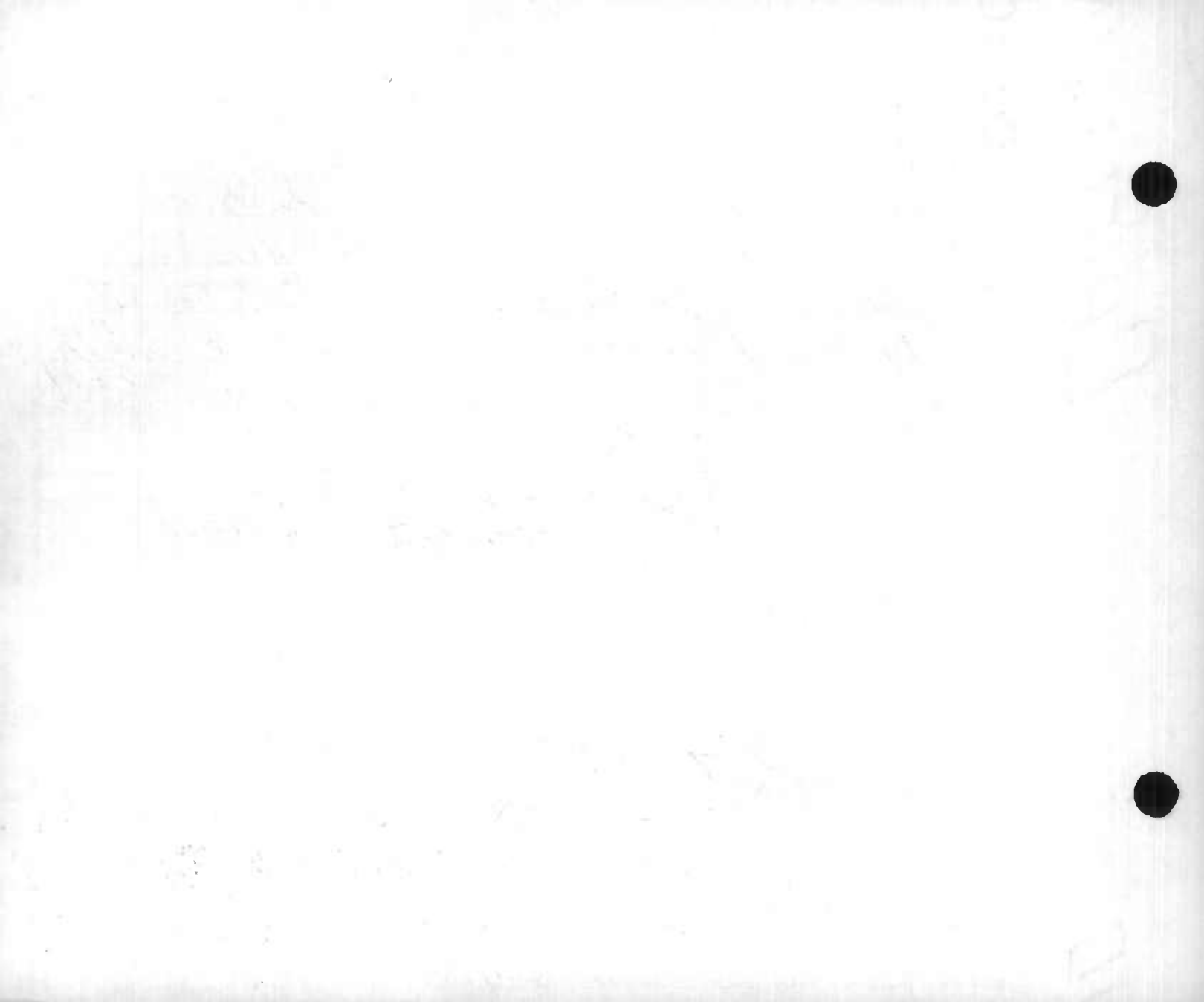
| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>John</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>2-18-85</i> | | | 2b. HOUR
M <i>7 AM</i> | | | | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>Col</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>10-10-1908</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>VA.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto. City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Providence Hosp.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Chauffeur</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>Maryland</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<i>3520 N. Hilton ST 21216</i> | | | |
| 14. FATHER'S NAME
FIRST <i>John</i> MIDDLE <i>Paterson</i> LAST <i>SR</i> | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Lucy</i> MIDDLE <i>Alice</i> LAST <i>Smith</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Mrs. Ruth Payne Gloucester Va.</i> | | | | ADDRESS
<i>23061</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aspiration Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Tracheobronchitis - Bacterial</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/14</i> 19 <i>85</i> to <i>2/18</i> 19 <i>85</i> that (I) (we) lost
saw the deceased alive on <i>2/14</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. Williams</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/18/85</i> | | |
| 22d. FUNERAL HOME'S NAME (TYPE OR PRINT)
<i>R. Williams</i> | | | 22e. ADDRESS
<i>4605 EDMONDSON AVE</i> | | | 22f. CITY OR TOWN
<i>29</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>BURIAL</i> | | | 23b. DATE
<i>2-23-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>James Store Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Gloucester Va.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Joseph L. Russ</i> | | | ADDRESS
<i>2222 W. North Ave</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 22 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



REG. NO

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified **immediately**.

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The
retained by the hospital or attending physician.

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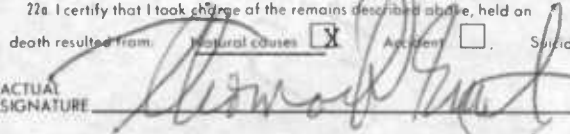
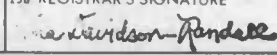
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CHIEF OF BUREAU, 1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|--|--|--|-----------------------------|---|--------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Willie Paylor | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. 2 9 19 85 | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 10 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
74 | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 9 19 85 | 7d. HOUR
8:49A | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2539 E. Biddle Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2539 E. Biddle St. 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Neatom Paylor | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Rogers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
246-09-7214 | | 17. INFORMANT ADDRESS
Jessie Jeffers 4403 Parkton Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Acting Chief MEDICAL EXAMINER | | | | DATE SIGNED 2/9/85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Roxboro, N.C. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |



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101100 2100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 FOR
STATE
REGISTRAR

REG. NO.

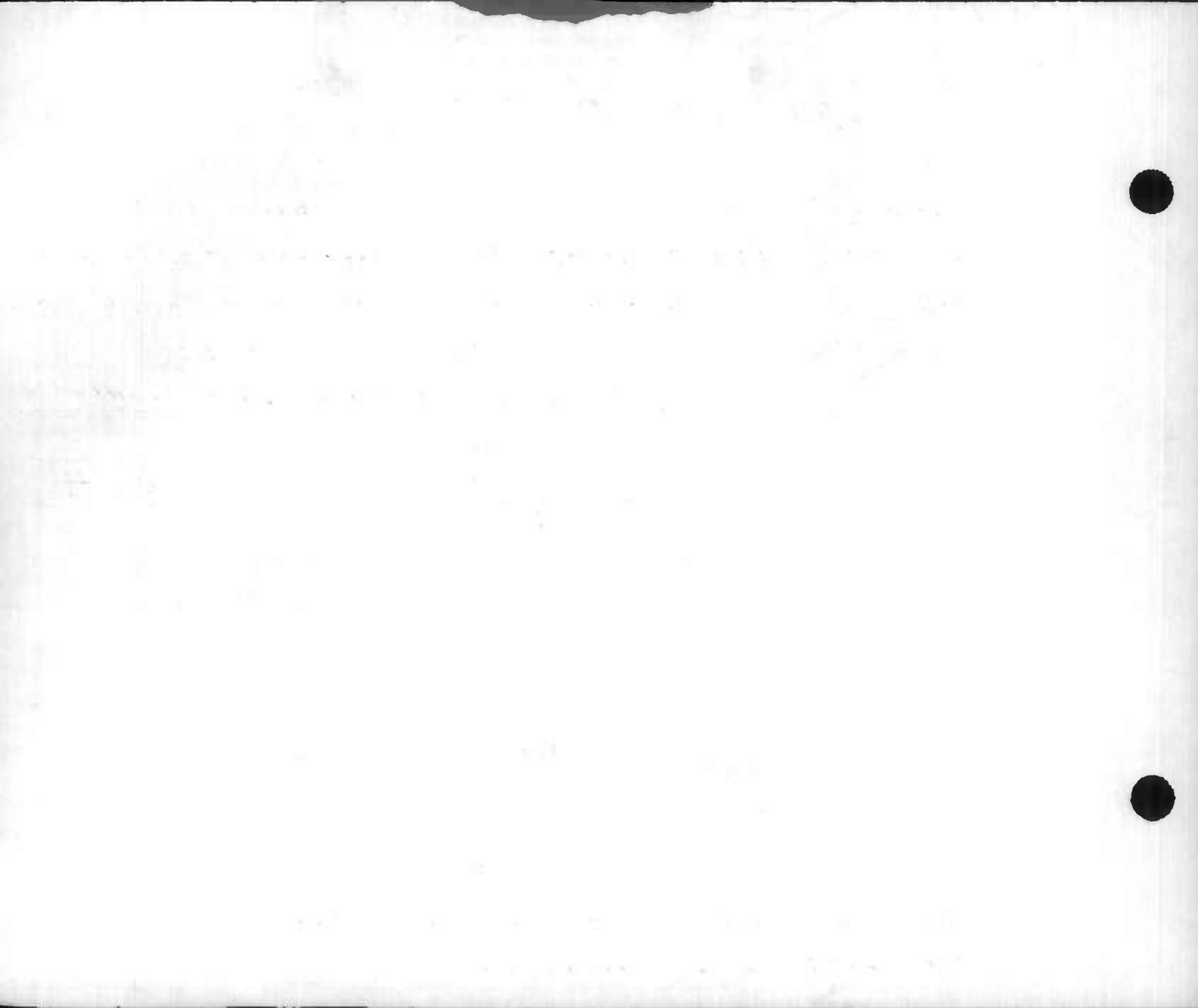
| | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EARI PEALS | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-3-85 | | | 2b. HOUR
930 AM | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
3-6-20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
523 McMECHEN ST | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LEGISLATIVE MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LUTHER POOL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARTHA PUMMER | | | 13e. STREET ADDRESS / ZIP CODE
523 McMECHEN ST 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT
MATTIE PEALS | | ADDRESS
523 McMECHEN ST | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) concealed pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF (b) retrograde pulmonary cell carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1/22 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3900 Loch Raven Blvd Towson, MD 21218 | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22 85 to 2/3 85 , that (I) (we) last saw the deceased alive on 1/30/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gwen Dubois | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/4/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gwen Dubois MD | | | 22e. ADDRESS
3900 Loch Raven Blvd Towson, MD 21218 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
2/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY
MD VETERANS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crown Hill MD | | |
| 24. FUNERAL DIRECTOR
NAME W F HAYES ADDRESS 634 N Colman St | | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1985 | | | 25b. REGISTRAR'S SIGNATURE
Gordon R. Riddle | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04660

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Alfonso F. Pedecine</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>Feb 23 85</i> | | 2b. HOUR
9:55 AM | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Dec 27, 1923</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>John L Deaton Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Unemployed</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Carmine A Pedecine</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lucy C Nittolo</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO.
<i>142-16-6704</i> | | 17. INFORMANT ADDRESS
<i>Carl C Pedecine 442 Millburn Ave 07041</i> | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Aspiration Pneumonia*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*2 days*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) *Anoxic Encephalopathy**1 month*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Asphyxia**40 yrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Head injury

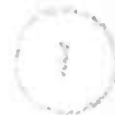
| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Head injury</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>9 1-21-85</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>Subject collapsed and struck head.</i> | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>street</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>800 Park Ave. Balto. Md.</i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>alfred J. Davis MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/24/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2/27/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St Rose Of Lima</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Short Hill New Jersey</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Leonard J Ruck Inc. Baltimore, Maryland</i> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<i>FEB 25 1985 [Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED 1967 JAN 10 11 40 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| SAMUEL PELOVITZ | | | | 2-09-85 | | | | 4:20 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | # UNDER 1 YEAR | | # UNDER 24 HRS. | |
| MALE | | CAUCASIAN | | 09 22 08 | | 76 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NEW YORK | | USA | | | | BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALT | | SINAI HOSPITAL | | | | PRINTER | | PRINTING | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| MD. | | | | | | BALT. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JOSHUA PELOVITZ | | | | ETHEL SIEGEL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| UNXXXXX YES WWII-NAVY | | | | 082074421 | | DAVID PAULSEN | | 15652 WOODFIELD PLACE SHERMAN OAKS, CA 91403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | | | 20 min. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2/1/85 | | Abdominal Aortic Aneurysm | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Sandra Robinson - Redway | | | | | | | | | | 2-9-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| SANDRA ROBINSON-REDWAY, M.D. | | | | | | SINAI HOSP. - BALTO., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| BURIAL | | FEB. 11, 1985 | | HEBREW YOUNG MEN | | BALTIMORE | | | | MARYLAND | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | | | | | FEB 19 1985 | | Sandra Robinson | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

BP

1945-1946

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1945-1946

1945-1946

1945-1946

1945-1946

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504662

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>WILLARD</u> <u>PENDER</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>2</u> <u>7</u> <u>85</u> | | 2b. HOUR
<u>2</u> P.M. |
| 3. SEX
<u>male</u> | 4. RACE
<u>B</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>6</u> <u>20</u> <u>20</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>64</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>N.C.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>BALTIMORE</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>BON SECOURS</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MARYLAND</u> 13b. COUNTY <u></u> 13c. CITY OR TOWN <u>BALTIMORE</u> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>1121 N. CAREY ST</u> <u>21217</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Edward</u> <u>Pender</u> SR. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
<u>Ida</u> <u>Pender</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>UNKNOWN</u> | | 16b. SOCIAL SECURITY NO.
<u>216091084</u> | | 17. INFORMANT
<u>COLLINE PENDER (WIFE)</u> ADDRESS <u>1121 N. Carey St</u> <u>21217</u> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPTIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(b) INFECTED PORTO FEMORAL GRAFT.

DUE TO, OR AS A CONSEQUENCE OF

(c) GANGRENE OF RIGHT ABOVE KNEE AMPUTATION STUMP

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c):

ARTERIO SCLEROTIC HEART DISEASE.

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION
<u>1/29/85</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GANGRENE OF THE ABOVE KNEE AMPUTATION STUMP</u> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>19</u> | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28/85</u> to <u>2/7/85</u> , that (I) (we) lost
saw the deceased alive on <u>2/7/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>BARTH A. S. Saxe</u> M.D. ATTENDING PHYSICIAN | | 22c. DATE SIGNED | |
| 22b. ADDRESS
<u>6911 PARK HEIGHTS AVE BALT MD 21215</u> | | | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | 23b. DATE
<u>2-11-85</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>MT AUBURN CEM</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BALTO</u> <u>MD</u> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>JOSEPH L. RUSS 2222 W. NORTH AVE</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 13 1985</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 6 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Daniel G. Penny | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 12 85 | | 2b. HOUR
1 PM M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Bus Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
MTA |
| 13a. STATE
MD | | | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Balto | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Foard Penny | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Berthe Izora Weichert | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-10-8004 | | 17. INFORMANT ADDRESS
Mrs. Shirley M. Hayes 3012 Putty Hill Ave. 21234 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Vascular Collapse

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pulmonary embolism

DUE TO, OR AS A CONSEQUENCE OF

(c)

Renal shutdown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Probable Left CVA

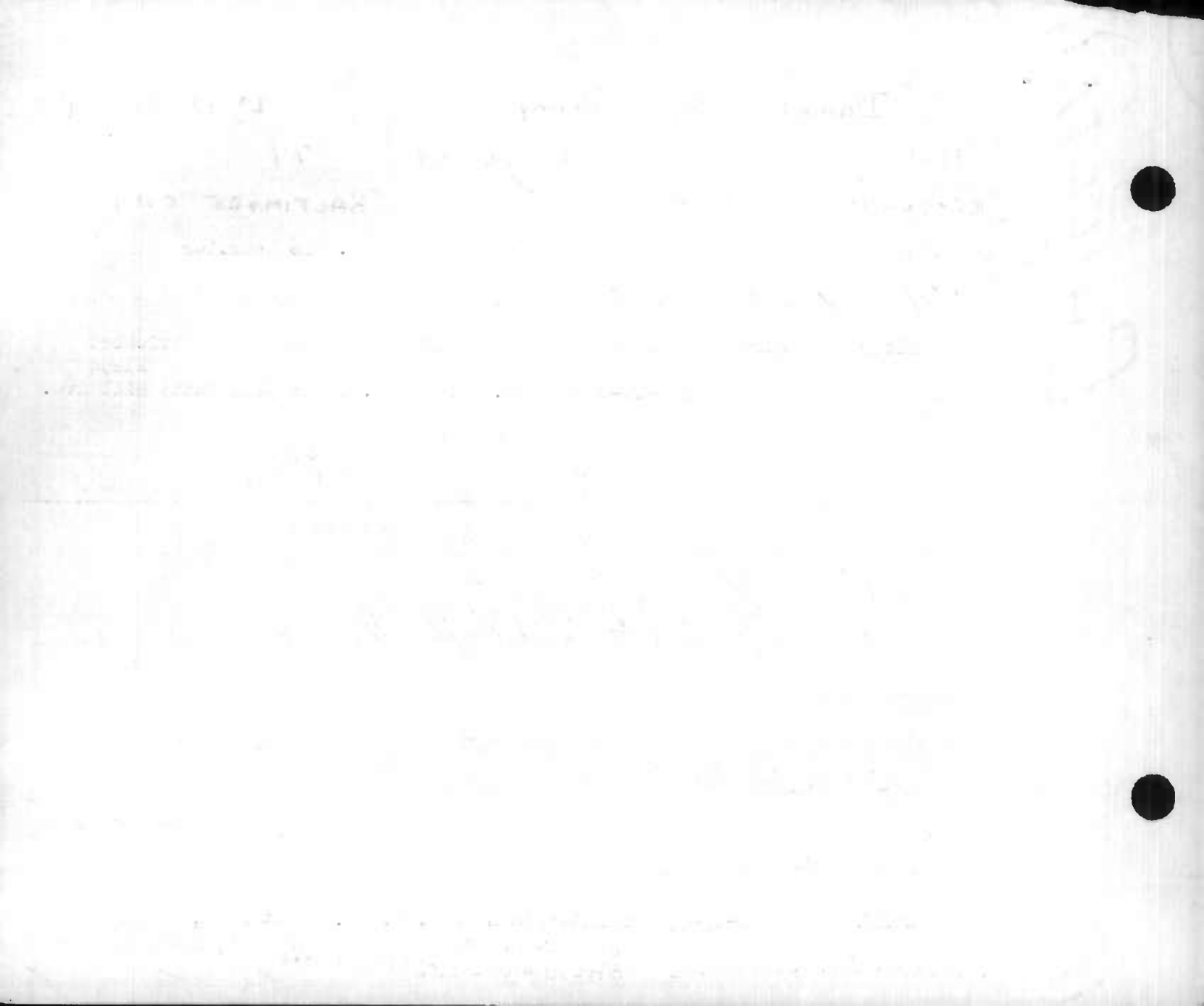
| | | | |
|---|---|--|---|
| 19a. DATE OF OPERATION
2-5-85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
31P Double barrel chest tube and to Diaphragmatic dx | 20a. AUTOPSY?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-5-85 19, to 2-12-85 , that (I) (we) last saw the deceased alive on 2-12-85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
L. R. Arguillano | | 22c. DATE SIGNED
2-12-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. R. Arguillano | | 22e. ADDRESS
G. S. H | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2-15-85 | 23c. NAME OF CEMETERY OR CREMATORY
Reisterstown Meth. Ch. Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Laasahn Funeral Home | | 25. DATE REC'D. BY REGISTRAR
FEB 19 1985 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 6 4

1- FOR
STATE
REGISTRAR

MD

REG. NO.

| | | | | | | |
|---|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <i>Annie</i> MIDDLE <i>Peoples</i> LAST <i>Peoples</i> | | | 2a. DATE OF DEATH
MONTH <i>Feb</i> DAY <i>5</i> YEAR <i>1985</i> | | 2b. HOUR
<i>11:30 AM</i> | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>BLACK</i> | | 5. DATE OF BIRTH
MONTH <i>1</i> DAY <i>7</i> YEAR <i>1896</i> | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTO</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>GREATER PENNSYLVANIA AVE. Nsg Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Machine Operator</i> | | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>BALTO</i> | | |
| 14. FATHER'S NAME
FIRST <i>Dennis</i> MIDDLE <i>Fields</i> LAST <i>Fields</i> | | 15. MOTHER'S MAIDEN NAME
FIRST <i>MARY</i> MIDDLE <i>JANE</i> LAST <i>FIELDS</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>226-09-7441</i> | | 17. INFORMANT
ADDRESS
<i>LILLIE LOCKETT 632 PAXSON ST</i> | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ventricular Arrhythmia</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>ASCD</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>IMMEDIATE</i>
<i>MANY Year.</i> |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CVA, HTN, Diabetes Mellitus, Decubitus ulcers.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-1-</i> 19 <i>84</i> , to <i>2-5-</i> 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>2-5-</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>SMITH M.D.</i> | | | | DEGREE
<i>M.D.</i> | | 22c. DATE SIGNED
<i>2-5-85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>SHAUKAT Y. KHAN</i> | | | | 22e. ADDRESS
<i>1528 KING WILLIAM DR, BALTO, MD</i> | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2/12/1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Carver Memorial Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suffolk, Virginia</i> | |
| 24. FUNERAL HOME OR PERSON
NAME ADDRESS
<i>Nutter & Sons 2501 Gwynns Falls Parkway
Funeral Home Inc. Baltimore, Maryland 21216</i> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<i>FEB 7 1985 [Signature]</i> | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

Machine C orator factory

100% COTTON
MADE IN U.S.A.



General Home Inc. Baltimore, Maryland 21202
Kutner & Sons 2501 Gayman Falls Parkway
Bristol 2812/1985 Carver Memorial Co. Suffolk, Virginia

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| James F. Peterson | | 2/19/ 19 85 | | 5:00 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| male | black | 2 11 62 | 23 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | NEVER MARRIED | Baltimore City, | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | University Hospital Shock Trauma | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 954 Seagull Avenue 21225 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| Frank Peterson | Henrietta Pugh | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | |
| NO | 220-78-5642 | Henrietta Pugh | 954 Seagull Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Multiple Gunshot Wounds | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | 2:05am 2/19/ 85 | | subject shot | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | stairway | | 725 George St., 4th fl., Balto. City, Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| | | M.D. Assistant | | 2/19/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | 23e. DATE REC'D. BY REGISTRAR | |
| BURIAL | 2/25/85 | Cedar Hill Cemetery | Anne Arundel Co., Md. | FEB 21 1985 | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm C March F/H Inc. | | 1101 E North Ave. | | | |

REENT VICTORY NO. 1

WINTER 1945



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JW-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| QUEEN | | ESTHER | | PETERSON | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2 24 1985 | | | | 2b. HOUR
6:57 AM | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | | |
| F | B | 8 23 29 | | 56 | | MONTHS DAYS | | HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 24 1985 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| HARRISVILLE S.C. | | USA | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 1327 Lemmon St. | | | | HOMEMAKER | | | | at home | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| MD | | | | BALTIMORE | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| | | | | YES | | | | NO | | | | 1327 Lemmon St | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | |
| SAM PETERSON | | | | GENOVA | | | | NO | | | | SUM PETERSON 1327 LEMMON ST | | | |
| 17. INFORMANT | | | | ADDRESS | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| SUM PETERSON 1327 LEMMON ST | | | | | | | | PART I DEATH WAS CAUSED BY: | | | | | | | |
| | | | | | | | | IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | | | (b) | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | YES | | | | NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | STREET | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | Autopsy | | | | Inspection | | | | Inquiry | | | |
| Natural causes | | | | Accident | | | | Suicide | | | | Homicide | | | |
| | | | | | | | | | | | | Undetermined manner | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant | | | | MEDICAL EXAMINER | | | | 2-24-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 111 Penn St., Balto., Md. | | | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | 2/28/85 | | | | Mt Auburn | | | | Baltimore MD 21230 | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Marshall P. Hays | | | | MAR 1 1985 | | | | Julia Davidson-Randall | | | | | | | |

WALLACE

93114 MOTTOS NO. 2

1911
J. B. Mottos
1911

1911
J. B. Mottos
1911

1911
J. B. Mottos
1911

1911
J. B. Mottos
1911

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSALINE A. PETERSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 18, 1985 | | 2b. HOUR
P M
2:00 P |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 23, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1 E. University Parkway (501) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Proprietor | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant |
| 13a. STATE
MD | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1 E. University Pkwy, 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(Unknown) | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Novak | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215 34 5320 | | 17. INFORMANT
ADDRESS
Vilma L. Peterson, Balto., MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION
2/9/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
_____ | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
_____ | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
_____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 2 1986 to Feb 18 1985 , that (I) (we) last saw the deceased alive on Feb 14 1985 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If two (do) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] DEGREE M.D. | | | | 22c. DATE SIGNED
2/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Edwin J. Berstock, MD | | 22e. ADDRESS
302 E. 33rd St., Balto., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/21/85 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | |
| 4905 York Road Balto., MD 21212 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

1975-2000

2015/5/5

2 • 62193

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

04669

FOR
1 - STATE
REGISTRAR

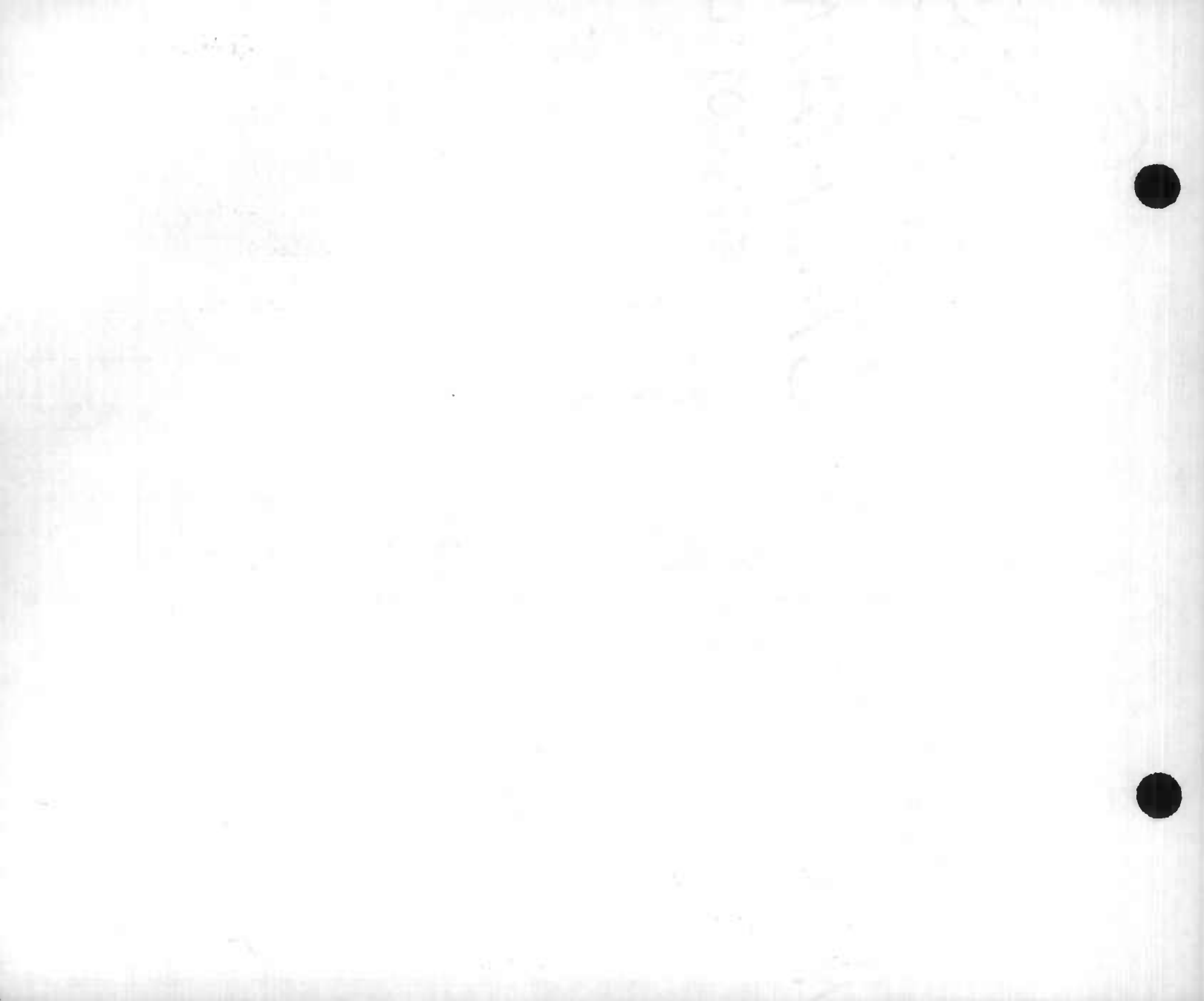
| | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) <u>LOUIS</u> FIRST <u>PETR</u> MIDDLE LAST | | | 2a. DATE OF DEATH MONTH <u>02</u> DAY <u>28</u> YEAR <u>85</u> | | | 2b. HOUR <u>3:00</u> P.M. | | | | | | |
| 3 SEX
<u>Male</u> | | 4 RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH <u>5</u> DAY <u>1</u> YEAR <u>14</u> | | 6 AGE (IN YEARS LAST BIRTHDAY)
<u>70</u> YRS | | 7 IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | 8 IF UNDER 24 HRS
HOURS <u></u> MIN. <u></u> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTO. CITY</u> MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
<u>Balto.</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>PROVIDENT</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>(patient)</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<u>Md.</u> | | | 13b. COUNTY | | 13c. CITY OR TOWN
<u>Balto.</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>1615 Park Ave. 21217</u> | | | |
| 14. FATHER'S NAME
FIRST <u></u> MIDDLE <u></u> LAST <u></u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u></u> MIDDLE <u></u> LAST <u></u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>Unkn.</u> | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>212-05-6924</u> | | 17. INFORMANT ADDRESS | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CA OF THE LUNG</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> 19 <u>85</u> , to <u>2-28</u> 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2-27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Eric Benning</u> | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>2-28-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ERIC BENNING</u> | | | | | 22e. ADDRESS
<u>3100 TOWANDA BOX 11</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Removal</u> | | | 23b. DATE
<u>3/4/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Anatomy Board</u> | | | | | ADDRESS <u>Balto., Md.</u> | | | 25a. DATE REC'D. BY REGISTRAR
<u>3-4-85</u> | | 25b. REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a death occurring on a day other than the day of death, the certificate must be filed with the registrar within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|---|--|--|---|---|---|--|---------------------------|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) BB-B TYRELL PETTIFORD (MILLER) | | | 2a. DATE OF DEATH
MONTH DAY YEAR FEB. 16, 1985 | |
| 3 SEX
male | | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 2 14 85 | | 2b. HOUR
9:03AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Pettiford | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Tammy Miller | | 13e. STREET ADDRESS / ZIP CODE
2523 E. Oliver St. 21213 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
C N/A | | 17. INFORMANT ADDRESS
Lois Miller 2523 E. Oliver Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.
(b) extreme prematurity
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min since birth ~42 hr | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I (this hospital) attended the deceased from 2/14 1985 to 2/16 9:03AM 1985 , that I (we) last saw the deceased alive on 2/16 9:03A 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bonnie Hudak | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bonnie Hudak | | 22e. ADDRESS
Johns Hopkins Hospital, Balt md 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Ave. | | | | 25. DATE RECEIVED BY REGISTRAR
FEB 19 1985 | | | |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 7 1

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNA MARIE PHILIPP | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 85 | | 2b. HOUR
10 ¹⁰ AM |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
6 1 90 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERIDIAN NURSING CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE REMING | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Aulbach | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
319-28-9640 | | 17. INFORMANT ADDRESS
Ashton, Md. 20861
Mr. Clarence Andrews 17701 Treelawn Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Senile dementia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/15/83</u> to <u>2/11/85</u> , that (I) (we) last saw the deceased alive on <u>2/11/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Alan Kimmel</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/11/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Alan Kimmel</u> | | 22e. ADDRESS
<u>222 W. Cold Spring La 21210</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>2/12/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore, Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Leonard J. Ruck, Inc.</u> | | ADDRESS
<u>Baltimore, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 13 1985</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

Bellevue, Wis.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and fill out page 4 of this certificate.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR
212186580 4460358
1/9/85 DR. THAUNG
MID. 2121835804 | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-10-85 12:54 PM | | | |
| 1. DECEASED NAME (TYPE OR PRINT) 2211 FIRST TAYLOR AVE. 21234
Phillips George A | | | | 2b. HOUR | | | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR 6 5 97 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10 CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13e STREET ADDRESS 21206 Ave. | | | |
| 13a STATE Md. | | 13b COUNTY - | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO. W.W.I | | 17 INFORMANT Cecelia R. Giese 4910 Benton Heights Ave. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac & respiratory arrested</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <u>Chung CCHU NG MD.</u> DEGREE MD. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Chung CCHU NG</u> | | | | 22e ADDRESS <u>Good Samaritan Hospital.</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 2-12-85 | | 23c NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24 FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. | | | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE FEB 14 1985 Julia Davidson-Randall | | | |

BP _____

1955

POSTAL 1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

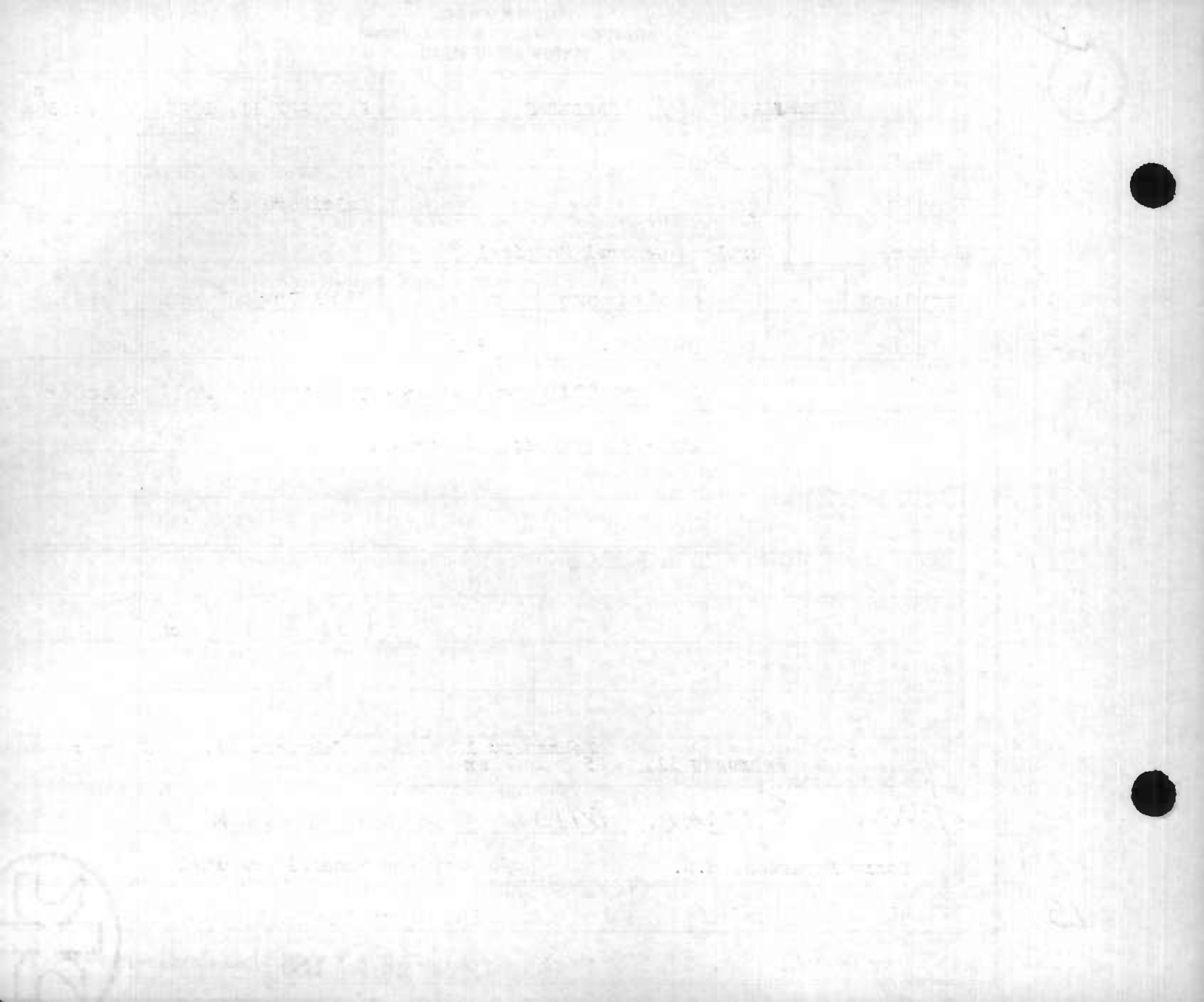
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|---|--|--------------------------------|---|--|--|-----------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NEHEMIAH N. PHILLIPS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11, 1985 | | 2b. HOUR
a
1:53 a | | | | | | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 5 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS
HOURS MIN.
00 00 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Jamaica | | 7b. CITIZEN OF WHAT COUNTRY?
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2119 Park Avenue 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Phillips | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie Cairn | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-09-5712 | | 17. INFORMANT
ADDRESS
Ervin Case 2109 Mount Holly Street | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (he/she) (this hospital) attended the deceased from February 10, 19 85 , to February 11, 19 85 , that (x) (we) last saw the deceased alive on February 11, 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) did (do not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Larry W. Epperson, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Larry Epperson, M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



8 5 0 4 6 7 4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
VERONICA PHILLIPS | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 28 85 | | | | 2b. HOUR
12 ⁵⁵ PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 23 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1700 DeSoto Road 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-48-2989 | | 17. INFORMANT ADDRESS
Bertha Zolynas 1803 Casadel Ave. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Paroxysmal Myocardial Infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/24/85</u> to <u>2/28/85</u> , that (I) (we) last saw the deceased alive on <u>2/28/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Jimmy Sue</u> | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. JIMMY SUE | | | | 22e. ADDRESS
St. Agnes Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Widson-Randall</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100-100

100-100

100-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon 20 papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 04675 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN MAE PHILLIPSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-2-85 2b. HOUR
2:18 PM | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
7 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Utah | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lincoln Conv. Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS
2654 Frederick Avenue 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frederick Scott | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maggie Casey | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-34-8973 | | 17. INFORMANT ADDRESS
Frances Curtian 2654 Frederick Avenue 21223 | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Collapse
DUE TO, OR AS A CONSEQUENCE OF (b) CVA with Rt hemiparesis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-4-84 to 2-2-85 , that (I) (we) lost saw the deceased alive on 2-2-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. | | | | | | | | | |
| 22b. SIGNATURE A-I. BAYKALER MD | | | | | 22c. DATE SIGNED 2-2-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-I. BAYKALER | | | | | 22e. ADDRESS 831 Poplar Grove St. Bal. 21216 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | 25b. REGISTRAR'S SIGNATURE | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Josephine Pinti | | | | February 2, 1985 4 P.M. | | | |
| 3 SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 6-14-1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 119 S. Robinson Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 119 S. Robinson Street 21224 | |
| 4. FATHER'S NAME FIRST MIDDLE LAST John Gatta | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clotilda PAPA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 812-22-346 | | 17. INFORMANT ADDRESS Florence Pinti, 119 S. Robinson St. 21224 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic degenerative Cardio Vascular disease
DUE TO, OR AS A CONSEQUENCE OF (b) CVA
DUE TO, OR AS A CONSEQUENCE OF (c) CHF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/13 19 78 to 2/2 19 85 , that (I) (we) last saw the deceased alive on 1/18 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph R. Liebert DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 2/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH R. LIEBERTO, M.D. | | 22e. ADDRESS 2508 BAY ST - Baltimore Md 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 4/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem | | 23d. LOCATION Baltimore, Md. STATE | |
| 24. FUNERAL DIRECTOR Joseph N. Zannino, 263 Adams St. Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 6 1985 | | 25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Antoinette | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-21-85 | | | 2b. HOUR
MIN.
5¹⁰ P M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 5, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
79 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Diatrician | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2707 Shirey Ave 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ciro Gelsomino | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Fiorella | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
212-40-2726 | | 17. INFORMANT
ADDRESS
Mrs Mary A Dushel 258 Chantry Rd 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 21 , 19 85 , to FEB 21 , 19 85 , that (I) (we) last saw the deceased alive on FEB 21 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Theodore Kramer | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2-21-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Theodore Kramer | | | | | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 22 1985 | | | |

5-27-32 2-9



| NAME | AGE | SEX | RACE | RELATIONSHIP | EDUCATION | INDUSTRY | REMARKS |
|---------------|-----|-----|------|--------------|-------------|-----------|---------|
| John Doe | 35 | M | W | Head | High School | Farmer | |
| Jane Doe | 32 | F | W | Wife | High School | Homemaker | |
| Robert Doe | 10 | M | W | Son | Elementary | School | |
| Mary Doe | 8 | F | W | Daughter | Elementary | School | |
| William Doe | 5 | M | W | Son | Elementary | School | |
| Elizabeth Doe | 3 | F | W | Daughter | Elementary | School | |

Continued on next page



Signature: _____ Date: _____

Official Seal: _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 7 8

1- FOR
STATE
REGISTRAR

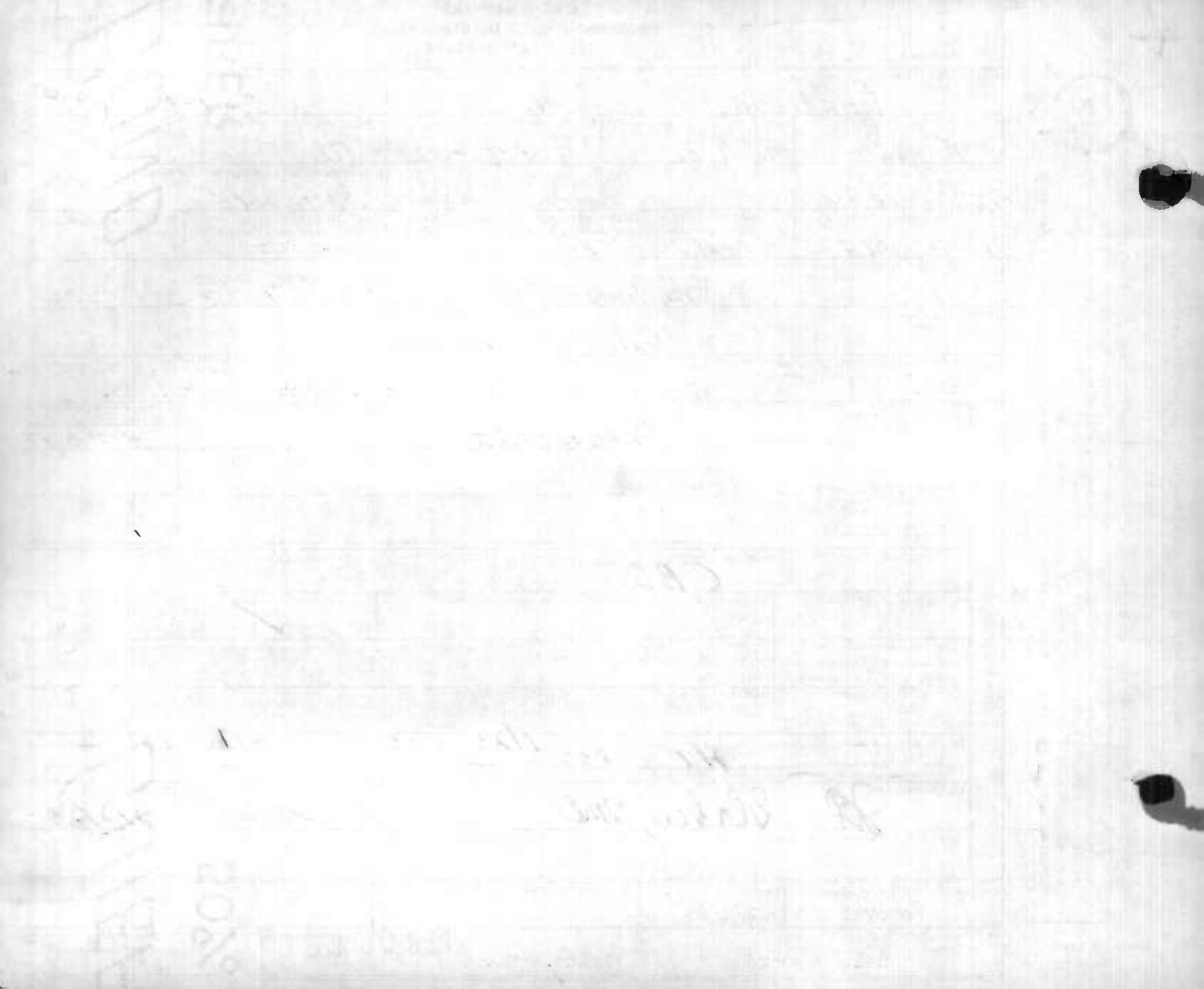
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Gertendo Plitt</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>2-1-85</i> | | | 2b. HOUR
<i>10:45 PM</i> | | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>9-7-02</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Baltimore, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<i>Md.</i> | | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, ZIP CODE
<i>611 S. Charles St. 21230</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Yates</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>AMANDA</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>Unkn.</i> | | | | |
| 16b. SOCIAL SECURITY NO.
<i>215-60-1674</i> | | | 17. INFORMANT
<i>Mr. August H. Plitt</i> | | | ADDRESS
<i>1336 S. Hanover St. Balto., Md.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>CBS</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that the (this hospital) attended the deceased from <i>1/23</i> , 19 <i>85</i> , to <i>2/1</i> , 19 <i>85</i> , that the (we) last saw the deceased alive on <i>1/21</i> , 19 <i>85</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above all (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Glader, MD</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/2/85</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Removal</i> | | | 23b. DATE
<i>2/2/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Anatomy Board Balto., Md.</i> | | | | | | | | | | |
| 25. DATE RECEIVED BY REGISTRAR
<i>FEB 06 1985</i> | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Deborah Gendall</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---|--|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| WILLIAM GARDNER PLITT | | | 02 01 85 | | | 4:15 A | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7b. HOUR | | |
| MALE | WHITE | 11 12 14 | 70 YRS. | | | 4:15 A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | ST. AGNES HOSPITAL | | EXECUTIVE | | | POSTAL SERVICE | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MARYLAND | | | --- | | | BALTIMORE | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13d. INSIDE CITY LIMITS? | | |
| FERDINAND PLITT | | | LOUISE LEMBACH | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| NO | | | 216-09-4058 | | | BLAINE CLENDANIEL | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>85</u> , to <u>Feb 1</u> , 19 <u>85</u> , that <u>he (we)</u> lost <u>saw the deceased alive on Feb 1</u> , 19 <u>85</u> , and that in <u>my (our)</u> opinion death occurred on the date and hour and from the causes stated above, (I <u>we</u> (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Bert F Morton</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/1/85</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>BERT F MORTON</u> | | | 22e. ADDRESS
<u>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | | 02-04-85 | | LOUDON PARK | | BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
<u>HUBBARD FUNERAL HOME, INC.</u> | | | ADDRESS
<u>4107 WILKENS AVE.</u> | | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 4 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson-Randall</u> |

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THE AMERICAN

AMERICAN ASSOCIATION

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AMERICAN ASSOCIATION

AMERICAN ASSOCIATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET L. PLUNKERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 26, 1985 | | 2b. HOUR
M
 | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 21, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
 | | IF UNDER 24 HRS
HOURS MIN.
 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3300 Echodale Ave. 21214 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Proof Reader | | | 12b. KIND OF BUSINESS OR INDUSTRY
 | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3300 Echodale Ave. 21214 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry W. Wolfe | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emily C. Zimmerman | | | 16. ADDRESS
1829 White Oak Ave. Elmer L. Plunkert, Jr. Balto. Md. 21234 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-32-1994 | | 17. INFORMANT
Elmer L. Plunkert, Jr. Balto. Md. 21234 | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Gracito Patricio, M.D.

2926 E. Cold Spring Lane Balto. Md.

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-1-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|---|--|---------------------------------|--|---|--|
| 1- REGISTRAR LEE DAVIS POLLOCK SR. CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LEE DAVIS POLLOCK SR. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 05 85 | | 2b. HOUR
7 ¹⁰ A M | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 22 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
President | | 12b. KIND OF BUSINESS OR INDUSTRY
Tesco Corp. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
COLUMBIA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT POLLOCK | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNE MCQUIRE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW2 | | 17. INFORMANT
ADDRESS
Lee Davis Pollock II 13758 Barberry Way
Sykesville, Md. 21784 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 MINUTES | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
(1) HIP FRACTURE. ACCIDENT | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/4/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
(1) HIP FRACTURE | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 2 1 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject fell | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
HOSPITAL | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Good Samaritan Hosp. BALD City MD | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 85, to 2/5 19 85, that (I) (we) last saw the deceased alive on 2/4 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Mark Adams MD. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/5/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK ALAN ADAMS MD. | | | | 22e. ADDRESS
LOCH RAVEN BLVD.
GOOD SAMARITAN HOSP.; BALTIMORE, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Md. | | | | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke Funeral Homes P.A.
5555 Twin Knolls Road, Columbia, Md. 21045 | | | | 25a. RECEIVED BY REGISTRAR
FEB 7 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | |

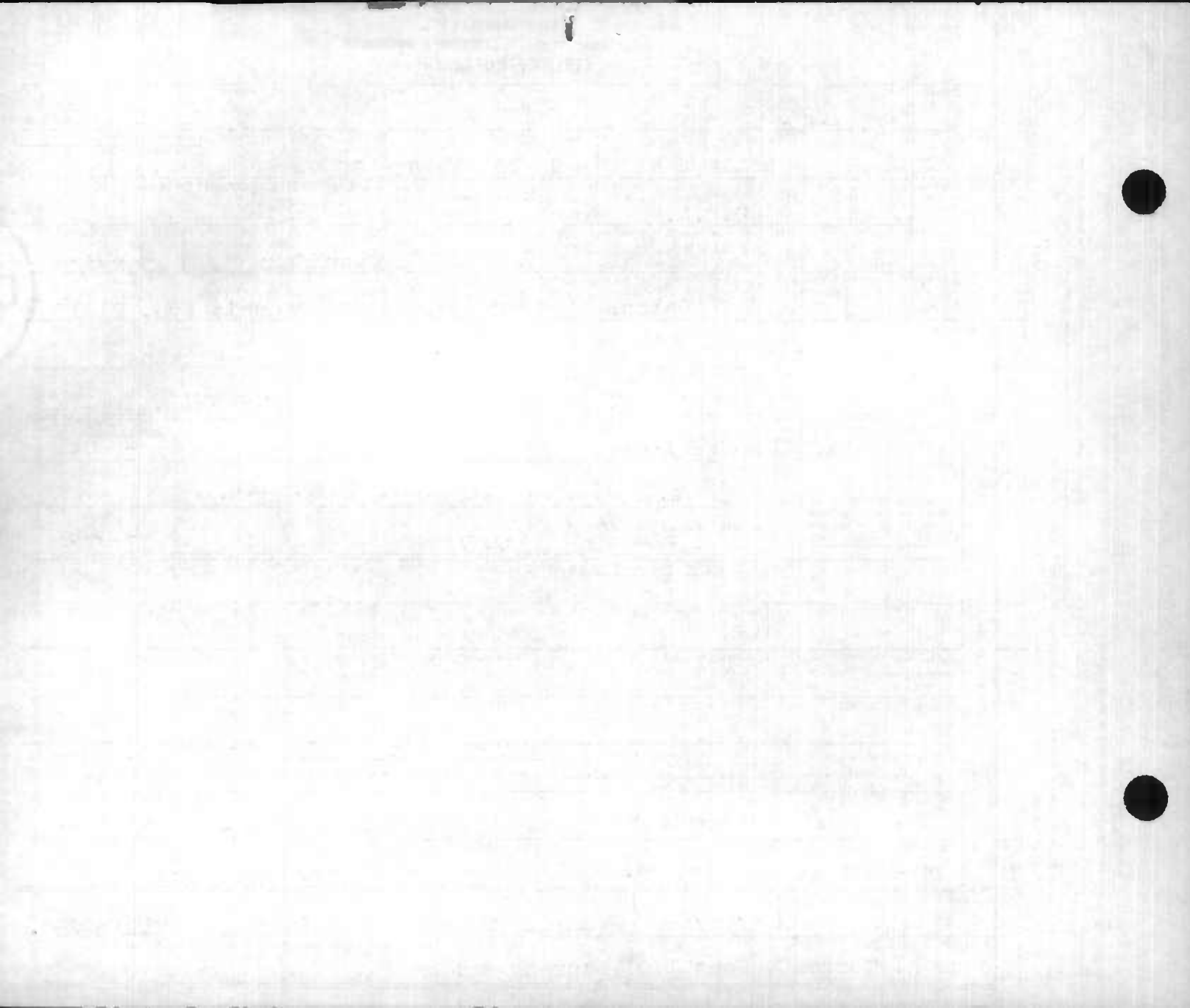
REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must sign and forward a copy of the

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HARVEY POLSTON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 19 85 | | 7b. HOUR
8:30p | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 29 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | # UNDER 1 YEAR
MONTHS DAYS | | # UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC 3900 LOCH RAVEN BLVD 21218 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chauffeur | | 12b. KIND OF BUSINESS OR INDUSTRY
Service | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3820 Sequoia Ave. 21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Polston | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Watkins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 216035271 | | 17. INFORMANT ADDRESS
VAMC 3900 LOCH RAVEN BLVD BALTO, MD 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Exacerbation of Chronic Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Probable Sepsis
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 4 days
4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 8, 19 85 to FEBRUARY 19, 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 19, 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Mark Allan Walker, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/20/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Allan Walker, MD | | | | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings R. K. Milford | | | |
| 24. FUNERAL DIRECTOR
NAME
Jas. A. Morton & Sons 1701 Laurens St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEV 22 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |



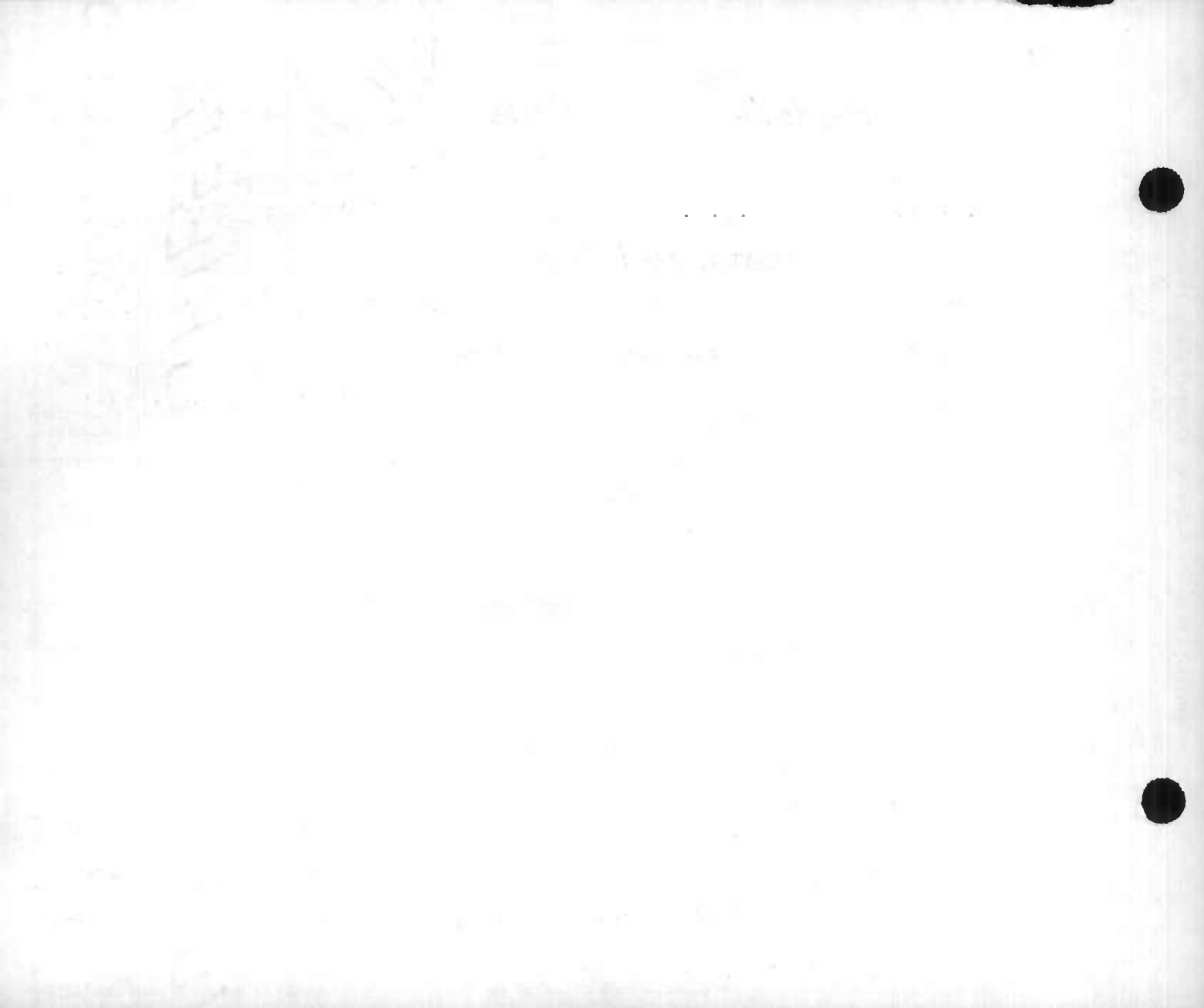
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Fredonia Ponds | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-21-85 | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 25 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Med. Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
611 S. Charles St. 21230 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Bedford Thompson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Annie Scott 813 N. Monroe Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Self-inflicted ulcer, pt. lip. c. sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD c. dementia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 13 19 85 to Feb. 21 19 85 , that (I) (we) last saw the deceased alive on Feb. 21 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. W. Reed
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/26/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. W. REED | | | | 22e. ADDRESS
611 S. CHAR. ST. BALG. MD 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdowne, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Viola Poole | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 28, 1985 | | 2b. HOUR
5:40 P_M | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/ 22/ 1917 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 8. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Billing Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | 13a. STATE
Md. | |
| 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Guth | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-16-9009 | | 17. INFORMANT
Frank Poole | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Disseminated Endometrial Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) Right Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive Cardiomyopathy, Anemia and Thrombocytopenia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Congestive Cardiomyopathy, Anemia and Thrombocytopenia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 13, 19 85 , to February 28, 19 85 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on February 28, 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 22b. SIGNATURE
S.A. Hashmi | | DEGREE
M.D. | | 22c. DATE SIGNED
3/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S.A. HASHMI | | 22e. ADDRESS
C/O Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardenas of Faith | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
B. Dabrowski & Son 2818 E. Baltimore St. | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson | | | |

Female

Case.

x

7/ 22/ 1917

Mo.

U.S.A.

Billings Clerk Hospital

Mo.

Baltimore

x

7008 Montrose Ave. 21237

Frank

Birth

Katie

Mo.

515-10-0009 Frank 1009 Montrose Ave.

Bureau

3/2/22

Department of Health

Baltimore Md.

B. Dabrowski & Son 2018 E. Baltimore St.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------|---|--------|---|----------|---|---|----------|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 02 18 85 | | | 12 15 AM |
| Henry Pope | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Male | White | 07 05 25 | | 59 | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| New Hampshire | | USA | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | SINAI HOSPITAL | | Retired-Social Security Admin. | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| MD | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13a. STREET ADDRESS | | 13b. STREET ADDRESS | | |
| Henry W. Pope | | Dora Cambell | | 3601 PINKNEY ROAD. | | 21215 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17b. ADDRESS | | |
| Yes | | WW 11 | | Mrs. Mercedes Pope | | 21215 | | |
| | | 049-18-1512 | | 3601 Pinkney Road Baltimore, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute MI; Internal bleeding.</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCVD; HTN</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Chronic kidney failure.</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-17-85</u> , 19 <u>85</u> , to <u>2-18-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-17-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Milan Wister</u> | | | | DEGREE | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | 22f. DATE SIGNED | | |
| DR. MILAN WISTER | | | | 2435 WEIT BELVEDERE AVE; BALTO | | 2/18/85 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | | Feb. 21, 85 | | Druid Ridge Cemetery | | Pikesville Baltimore MD. | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Loring Byers Funeral Directors, Inc. | | | | FEB 19 1985 | | Linda Davidson-Randall | | |
| 8728 Liberty Road Randallstown, MD. 21133 | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--------------------------------------|---|---|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| Ola B. Pope | | 2-2-85 | | 5 ⁰⁰ P. M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | Black | MONTH DAY YEAR | 72 YRS | Baltimore City, MD. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City, MD. | Baltimore | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Francis Scott Key Medical Ctr. | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | BALTO. | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2505 Peck Avenue 21219 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| Willie E. Porter | | Novella Allmond | | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| NO | | 212-30-0154 | | 17. INFORMANT ADDRESS | |
| | | | | Mary Jones 2505 Peck Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cerebral vascular disease | | | | | days |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Periphr. Cerebral | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal hemorrhage | | | | | wks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Diabetes mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 11/2/84 to 2/2/85, that (2) (the) last seen the deceased alive on 2/2/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. 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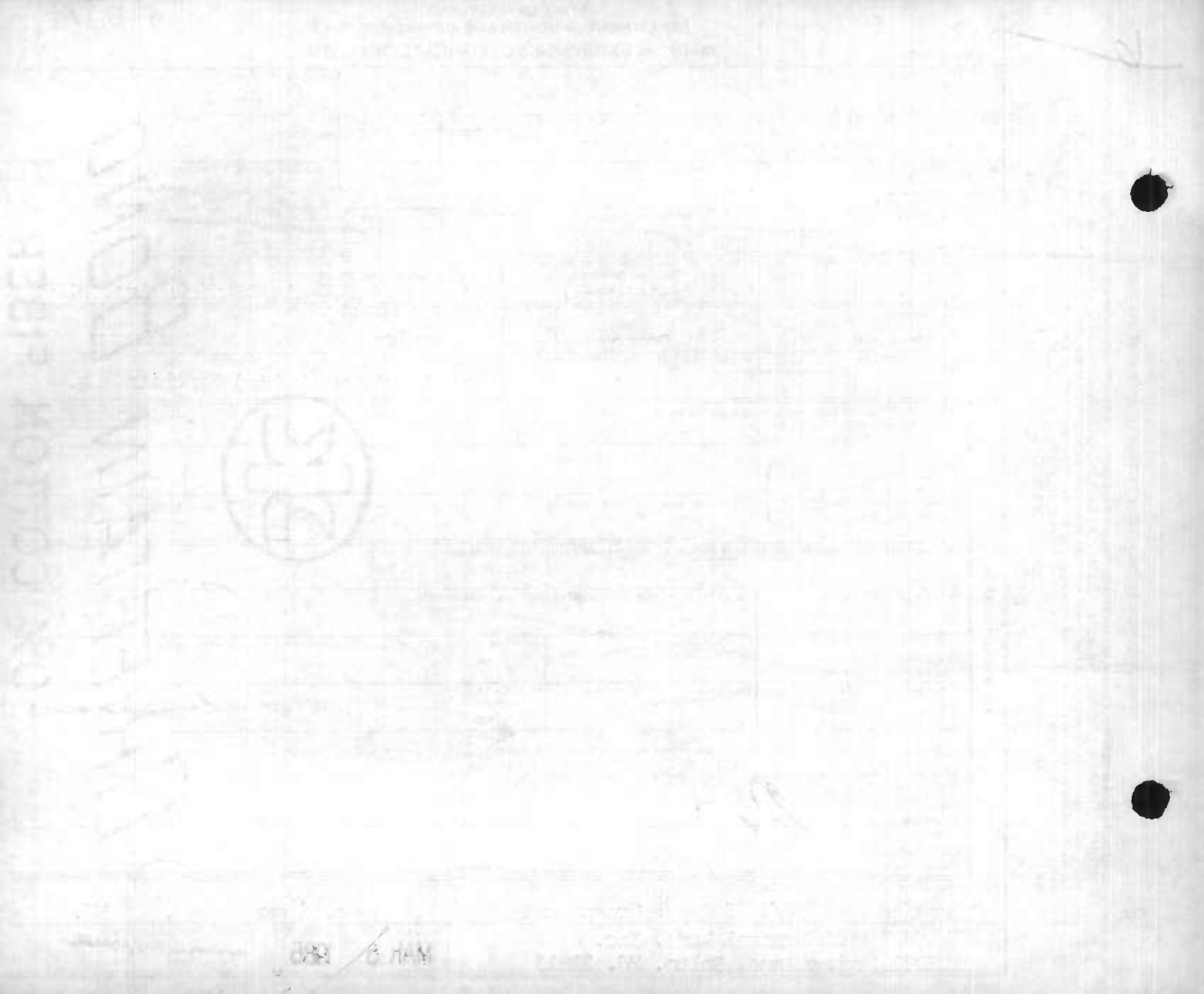
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|---|---|---|---|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Norbert O. Popper | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 2/27/1985 | | 2b. HOUR 4:30 P | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 19 1892 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
92 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
2/27/1985 | | 7d. HOUR 4:30 P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3937 Chesterfield Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Car Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Keller Mtrs. | | | |
| 13a. STATE
Md. | | | 13b. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3937 Chesterfield Ave. 21213 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norbert Popper | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
214-14-8807 | | 17. INFORMANT ADDRESS
Hazel Brigham (dghtr) Ranchita, Ca. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 2/28/85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
3/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAK 5 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



Item 13e per call M.E.O. 2/8/85 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

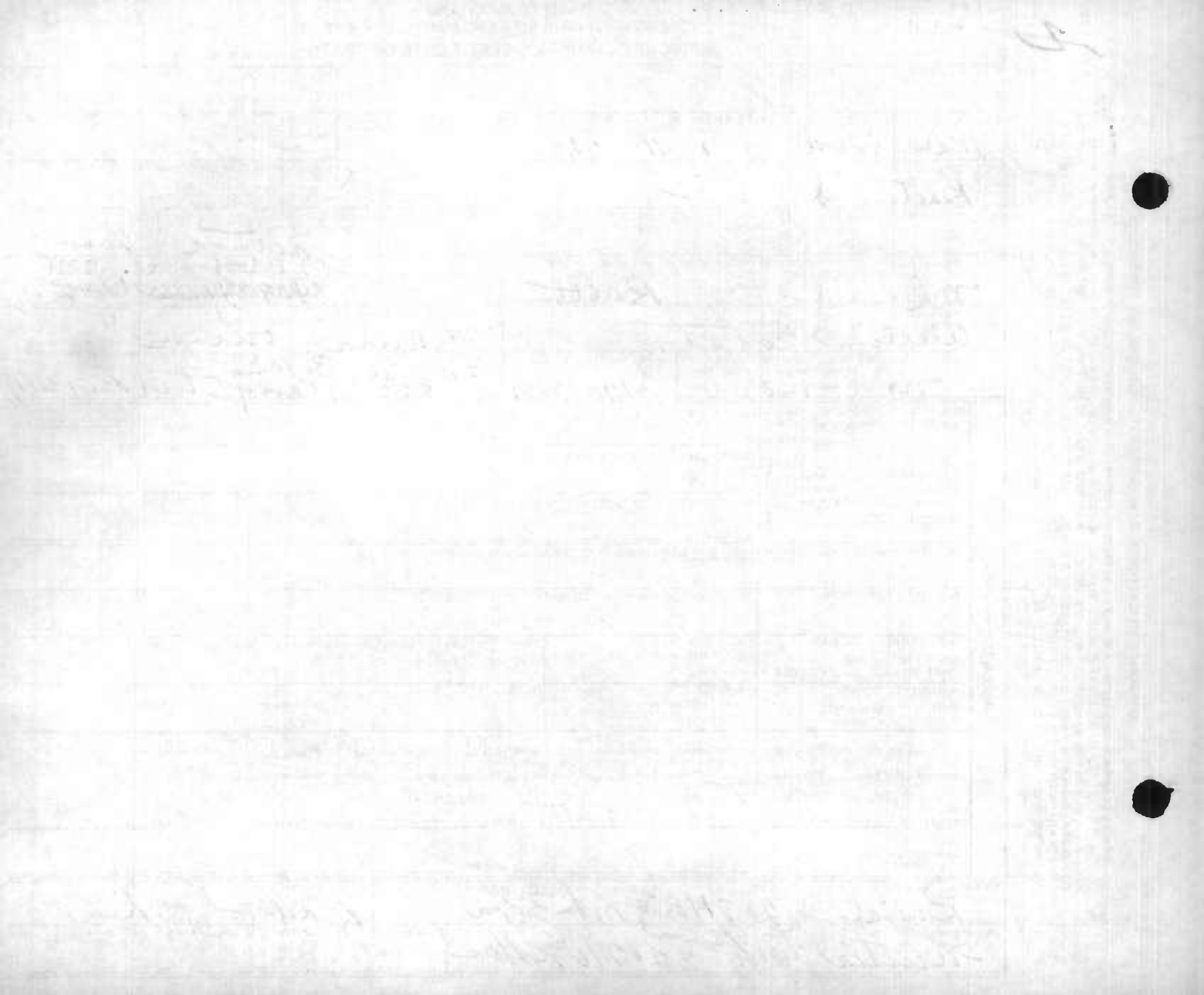
| | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Anthony Porter | | | | | | | | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 2-2 1985 | | 11:50 a. M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| male | Black | 9 1 11 | | 73 YRS. | | MONTHS DAYS HOURS MIN | | | | 2-2 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Baltimore | | USA | | | | Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Provident Hospital | | | | retired | | Cuba | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | t | | Balt | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3609 Fairview Ave. 21216 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | |
| William Porter | | Lana Owens | | | | 16b. SOCIAL SECURITY NO. 214633746 | | | | | |
| 16c. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16d. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | |
| no | | no | | | | Lamine B. King 823 A Carey Street Bldg 1117 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | DATE SIGNED 2-2-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | 2/8/85 | | | | Mt Zion | | | |
| 23d. LOCATION CITY OR TOWN | | | | COUNTY | | | | STATE | | | |
| Baltimore | | | | t | | | | MD | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| William M. 3207 W. Pratt | | | | | | FEB 4 1985 | | William M. Randall | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Denton Ezra Powell | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 22, 1985 | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 8 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81
YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Agriculture | |
| 13a. STATE
Maryland | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Union Bridge | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert David Powell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Jane Feeser | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16a. SOCIAL SECURITY NO.
213-03-6221 | | 17. INFORMANT
ADDRESS
Dolores M. Roberson 8112 Redview Drive Forestville, MD 20747 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bilateral Pneumonia
(c) Urinary Tract Infection and Sepsis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 7, 1985 , to February 22, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 22, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. Shaker | | DEGREE
M.B.S. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. Shaker (M. SHAKER) | | 22e. ADDRESS
C/O Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 25, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Valley Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pleasant Valley, Carroll, MD | |
| 24. FUNERAL DIRECTOR
NAME
Skiles Funeral Home | | 24b. ADDRESS
136 E. Baltimore St. Taneytown, MD 21787 | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | |

214-6-2577 (Revised 1-1-60) (Revised 1-1-60)

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|---|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Theodore Prater Sr.</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>February 17, 1985</i> | | 2b. HOUR
<i>5:30 P.M.</i> | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1 19 24</i> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>61</i> | | 7. AGE UNDER 1 YEAR
MONTHS DAYS
<i>61</i> | | 8. AGE UNDER 24 HRS
HOURS MIN.
<i>61</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Maryland General Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
<i>1724 Homestead Ave. 21218</i> | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13c. STATE
<i>Maryland</i> | | 13d. COUNTY
<i>Baltimore</i> | | 13e. CITY OR TOWN
<i>Baltimore</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William Prater</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Helen McCall</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>YES</i> | | |
| 16b. SOCIAL SECURITY NO.
<i>218-12-0923</i> | | 17. INFORMANT
ADDRESS
<i>Verna Mae Prater 1724 Homestead Ave.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Chronic Renal Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Gastro-intestinal bleeding</i> | | | | | | |
| 19a. DATE OF OPERATION
<i>2/2/85</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Infection of right arm (site of Gortex Graft)</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>January 29, 1985</i> , to <i>February 17, 1985</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>February 17, 1985</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>Barbara H. Sanford M.D.</i> | | |
| 22c. DATE SIGNED
<i>2/17/85</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Barbara H. SANFORD M.D.</i> | | 22e. ADDRESS
<i>c/o Maryland General Hospital</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>2/22/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Garrison Forest VA</i> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Owings Mills, Md.</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Wm C March F/H Inc. 1101 E North Avenue</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 20 1985</i> | | |
| 25b. REGISTRAR'S SIGNATURE
<i>a Davidson-Randall</i> | | 25c. REGISTRAR'S NAME
<i>a Davidson-Randall</i> | | 25d. REGISTRAR'S ADDRESS
<i>a Davidson-Randall</i> | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

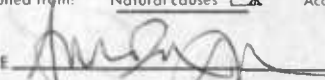
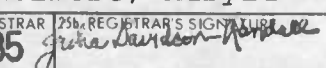
91614

11011

WMD



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | |
|--|--|------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BARBARA A. PRATT | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 21 1943 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
41 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 8 19 85 | | 2d. HOUR
2:26 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
711 N. Calhoun St. 21217 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Pratt | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Caroline Biggust | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Calhoun
Ms. Barbara Ann Pratt 711 N. St. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Alcoholism</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-8-85 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F.H., Inc. | | | | | | ADDRESS
1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | | | 25b. REGISTRAR'S SIGNATURE
 | |

STATE OF NEW YORK
IN SENATE
JANUARY 15, 1903

LIBER

COLLECTION

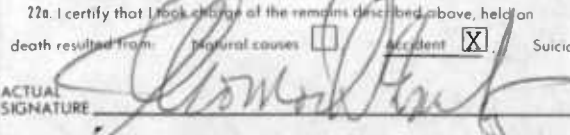
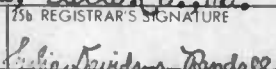
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UNIVERSITY OF CALIFORNIA



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|---|--|---|---------------------------------------|---|--|---|-------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William George Preller | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 9 19 85 | | 2b. HOUR M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 4 12 21 63 YRS. | 6. AGE (IN YEARS)
LAST BIRTHDAY 63 | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS.
HOURS MIN. | 9. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 9 19 85 | 2d. HOUR 5:35A | | 2e. HOUR M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Esskay Meat | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3301 Leventon Avenue 21224 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Preller | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Campbell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | (IF YES, GIVE WAR OR DATES)
W.W. 2 | | 16b. SOCIAL SECURITY NO.
218-07-4887 | | 17. INFORMANT ADDRESS
Aurora Preller 3301 Leventon Ave. 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural hematoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:30 PM 2 9 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject fell down stairs | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3301 Leventon Ave, Baltimore MD. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Acting Chief MEDICAL EXAMINER | | | | DATE SIGNED 2/9/85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2-12-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westview, Balto., Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Charles S. Zeiler & Son Inc. 901 S. Conkling St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

11

Walter
Baker

1900

1900 10 21

U.S.A.

Walter

Walter

Walter

1900 10 21

x

Walter

Walter

Walter

Walter

Walter

Walter

1900 10 21

1900 10 21

U.S.A.

Walter

NOTED 2X03

Walter



Walter Baker 1900 10 21
Walter Baker 1900 10 21

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|---------|-----------------------------------|-------------------|---|---------------------|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST
Lawrence Anthony Preston | | | | X MONTH DAY YEAR
2/ 6/ 1985 | | | | 2b. HOUR
9:00 A M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | 2e. MIN. | |
| male | black | 7 10 45 | 39 YRS. | MONTHS | DAYS | 2c. DATE PRONOUNCED DEAD
2/ 6/ 19 85 | | 2d. HOUR
A M | | 2e. MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| Maryland | | U.S.A. | | X NEVER MARRIED | | Baltimore City, | | Baltimore | | 306 W. Franklin St., Room 205 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| | | | | YES X NO | | 2306 Winchester St. 21216 | | Baltimore | | YES X NO | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| FIRST MIDDLE LAST
Berlie Preston | | | | FIRST MIDDLE LAST
Maggie Audrey | | | | YES NO | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| 214-44-1623 | | | | Barbara A. Preston | | | | PART I DEATH WAS CAUSED BY: | | | |
| 2027 N. Pulaski St. | | | | | | | | IMMEDIATE CAUSE (a) Gunshot Wound to Head | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | | | (b) | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES NO X | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| X | | | | 9:00xx 2/ 6/ 19 85 | | | | self-inflicted wound | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | |
| WHILE AT WORK NOT WHILE AT WORK X | | | | hotel room | | | | 306 W. Franklin St., Balto. City, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy [] Inspection X Inquiry [] and in my opinion death resulted from: Natural cause [] Accident [] Suicide X Homicide [] Undetermined manner [] | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| [Signature] | | | | M.D. Assistant | | | | 2/6/85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 111 Penn St. | | | |
| Gregory R. Kauffman, M.D. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| BURIAL | | | | 2/11/85 | | | | Md. Veteran Cemetery Crownsville, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | | | FEB 8 1985 | | | | Julia Davidson-Randall | | | |
| Wm C March F/H Inc. 1101 E North Ave | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified of choice.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

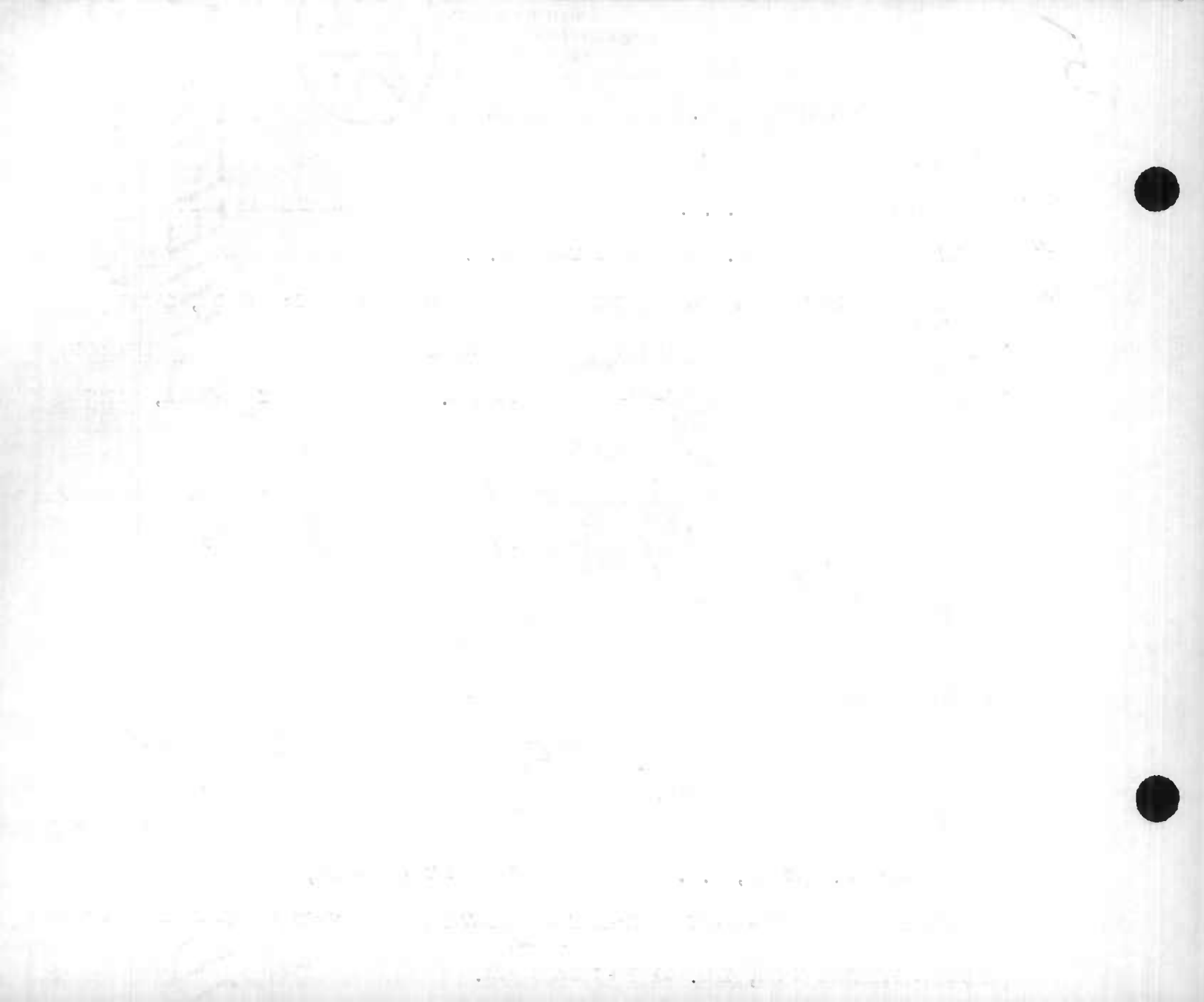
8504694

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|-------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| CHARLES C. PRICE | | | | | | 02 02 85 | | | | 9:42A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| MALE | | WHITE | | 06 15 08 | | 76 YRS. | | | | | |
| 7a. BIRTHPLACE
(COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | ST. AGNES HOSPITAL E.R. | | | | WAREHOUSEMAN | | FOOD SERVICE | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 824 5TH AVENUE, 21227 | | | |
| MARYLAND | | BALTIMORE | | LANSDOWNE | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| MORRIS PRICE | | | | LILLIAN UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 216-05-5032 | | ADDIE M. PRICE | | 824 5TH AVENUE, 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10).
<u>C.V.H.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1981</u> , 19 <u>81</u> , to <u>2 Feb</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
<u>William J. Bryson</u>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>4 Feb 85</u> | | | |
| WILLIAM J. BRYSON, M.D. | | | | | | 5772 WESTVIEW MALL, 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | 02-05-85 | | HAMPSTEAD CEMETERY | | HAMPSTEAD CARROLL MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | | | FEB 4 1985 | | <u>John Davidson-Randall</u> | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 9 5

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|-------------------------------|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leona S Price | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 04 85 | | | 2b. HOUR
4:15 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 11 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 15. KIND OF BUSINESS OR INDUSTRY
Domestic | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Maryland | | | 17. COUNTY
BALTO. | | 18. CITY OR TOWN
Baltimore | | 19. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. STREET ADDRESS / ZIP CODE
941 Foxcroft Lane 21221 | |
| 21. FATHER'S NAME
FIRST MIDDLE LAST
William Preecs | | | 22. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belle Dobson | | | 23. ADDRESS
941 Foxcroft Lane
Baltimore, Maryland 21221 | | | | |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 25. SOCIAL SECURITY NO.
407-22-2690 | | 26. INFORMANT
David Price | | 27. ADDRESS
Baltimore, Maryland 21221 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) double pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Diabetes, S/P stroke

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/3/85</u> , 19 <u>85</u> , to <u>2/4</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2/3/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Brenda W. Cooper</u> | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/4/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Brenda W. Cooper</u> | | | | 22e. ADDRESS
<u>Francis Scott Key Medical Ctr</u> | | | |

MEDICAL CERTIFICATION

1

| | | | | | | | |
|--|--|---------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-8-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Morehead, Rowan, Kentucky | |
| 24. FUNERAL DIRECTOR
NAME
Marzullo Funeral Service | | | | ADDRESS
Reisterstown, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1985 | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

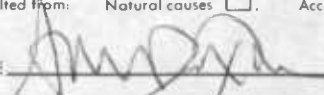
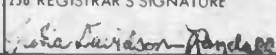
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified by a physician.

0053-2235/92/0005-0000\$05.00/0

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT N. PRICE | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 2 23 19 85 | | 2b. HOUR AM | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR July 2, 1957 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 27 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 23 19 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4102 Edmondson Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Construct. | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4102 Edmondson Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST James Price | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Ozelia Moore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-68-2004 | | 17. INFORMANT Ozelia Price | | ADDRESS 4102 Edmondson Ave. Baltimore, Md 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of chest (handgun)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR 10:50 AM 2-23- 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subjec shot. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE 4102 Edmondson Ave., Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-24-85 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-28-85 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Arbutus Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
Marshall W. Jones, Jr. ADDRESS 4101 Edmondson | | | | | | 25. DATE REC'D. BY REGISTRAR FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE  | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Tina Elizabeth Price | | 2a. DATE OF DEATH
MONTH DAY YEAR 02-08-85 | | 2b. HOUR
9:40 A M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR July 26, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Edward Heath | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mandy Jane (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
190-12-0376 | | 17. INFORMANT
Cherry Tree Cross Rd. Box 40
Eugene R. Price, Cheltenham, MD 20623 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY ARTERY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSSIBLE PNEUMONIA, OLD CVA-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>POSSIBLE PNEUMONIA, OLD CVA-</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10/84, 1985, to 2/8, 1985, that (I) (we) last saw the deceased on 2/8, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Luis E. Rivera</i> | | DEGREE | | 22c. DATED
2/8/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Luis E. Rivera, M.D. | | 22e. ADDRESS
5317 Belair Road
Baltimore, Md. 21206 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Feb. 11, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Stabler's Cemetery Parkton, Baltimore, MD | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. FUNERAL DIRECTOR
J.J. Hartenstein, New Freedom, PA 17349 | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01:00

00-0000

11:00

11:00

11:00

Female

Male

Male

to

Baltimore City

Baltimore City

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 6 9 8

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LILLIAN LILLIAN MAY PRIETZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 2, 1985 | | | 2b. HOUR
3:20 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 3, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE EGNARA HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | |
| 13a. STATE
MD | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GLEN BURNIE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
112 VISTA AVE 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK H. NEVINS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAUDE M. OWENS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO N/A | | | | | | |
| 16b. SOCIAL SECURITY NO.
21374 7257 | | 17. INFORMANT (DAUGHTER)
MRS. MAUDE M. GRIM SAME AS 13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>PAGETS DZ, DM, HTN, ALZHEIMERS DZ</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 27</u> , 19 <u>85</u> , to <u>February 2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>February 2</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. Douglas Clarke | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-1-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Douglas Clarke | | | | | 22e. ADDRESS
6524 Cedar Furnace Cir., Glen Burnie | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
FEB. 5, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
SINGLETON FUNERAL HOME GLEN BURNIE, MD | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified and a post-mortem examination required.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

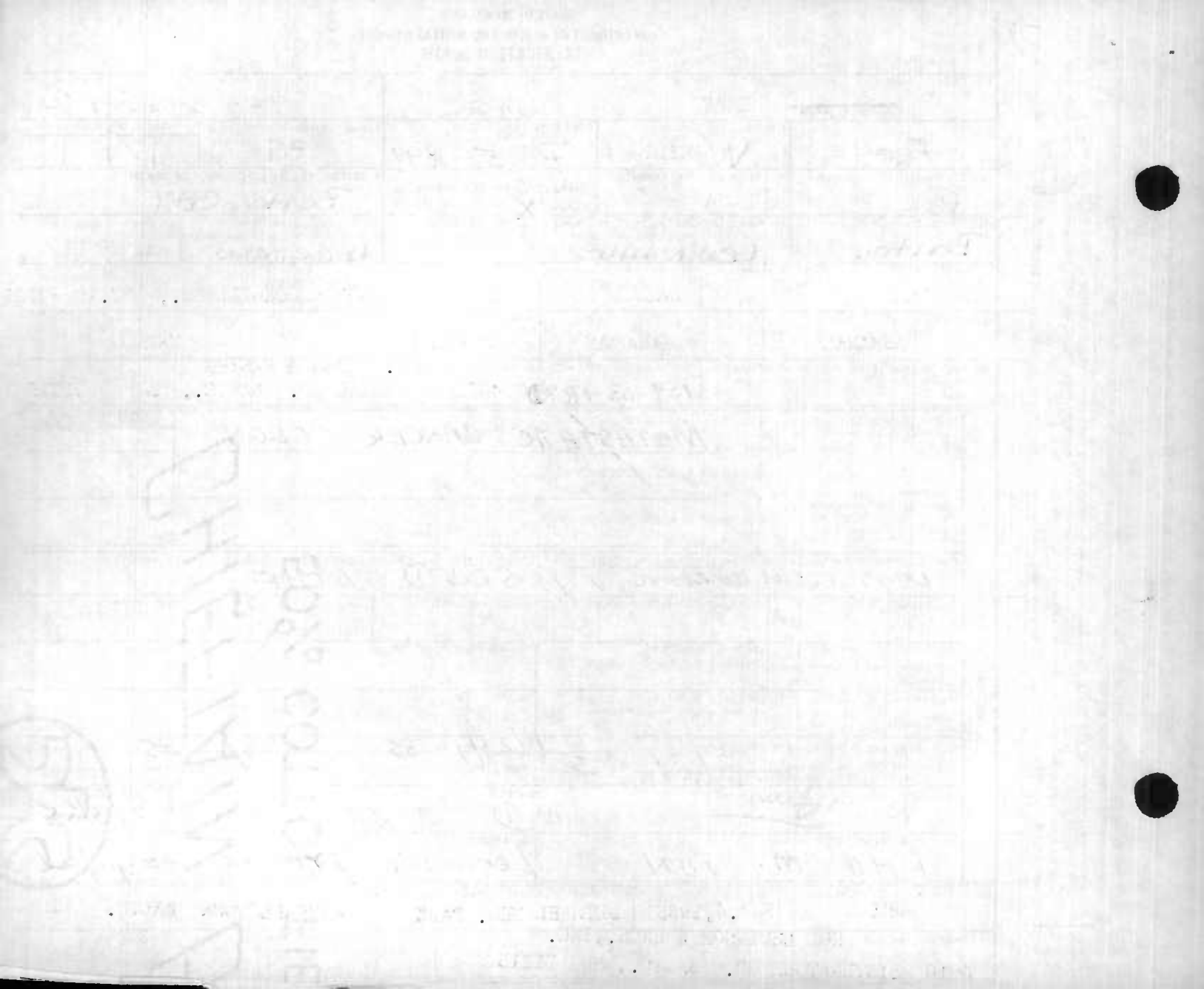
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) SARA H. SARA PRINCE | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-3-85 | | 2b. HOUR 8:45 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 4 5 1899 | 6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto., City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND 13b. COUNTY Balto. | | | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM GOLDMAN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 159-03-17080 | 17. INFORMANT MRS. BARBARA MASTER | | 17b. ADDRESS 4002 BROOKHILL RD. BALTO., MD 21215 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CANCER COLON
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Pernicious anemia, A.S.C.V.D. Hb CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3/85 to 2/3/85, that (I) (we) last saw the deceased alive on 2/3/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/3/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATH M. TUN | | 22e. ADDRESS Levindale Geriatric Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE FEB. 4, 1985 | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR FEB 6 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward S. Pruitt | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 28 85 | | | 2b. HOUR
1:25 PM | | | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/9/08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Medical Cen. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR WHICH WORKING LIFE)
Operator | | 12b. KIND OF BUSINESS OR
Standard Marine Co. | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4910 E. Federal St. 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Pruitt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Evans | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
1941-1942 | | 17. INFORMANT
Elmer Pruitt, 7930 St. Bridget Lane | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>hypertension, severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | #21222 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>85</u> to <u>2/28</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edith Leppold</u> | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/1/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E Leppold | | | | 22e. ADDRESS
4940 Eastern Ave | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL HOME
NAME ADDRESS
Sohamunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 5 1985 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 0 1

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian Pryor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 28 85 | | | 2b. HOUR
3:36 PM | | | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/25/19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1721 Register Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1721 N. Register St 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar Douglass | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Warner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
217-22-3130 | | 17. INFORMANT
ADDRESS
Ella Leach 1721 N. Register St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Long cancer with metastases to the ribs
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Coronary artery disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10-21 , 19 84 , to 2-22 , 19 85 , that (1) (we) last saw the deceased alive on 2-22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Chi-Shiang Chen | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3/1/85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Chi-Shiang Chen, M.D. | | | 22e. ADDRESS
100 N. Broadway Balto., MD 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Ave | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

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9
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 0 2

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
REBECCA L. PUMPHREY | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 4, 1985 | | 2b. HOUR
5:10 A.M. |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 16 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | # UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ESSEX Co., VA. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY LEE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIRGINIA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
220-07-9143 | | 17. INFORMANT ADDRESS
RANDOLPH LEE 2225 GUILFORD AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes mellitus, hypertension
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary edema | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1985, to Feb 4, 1985, that (I) (we) lost
saw the deceased alive on Feb 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John P. Jerlembor | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/4/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John P. Jerlembor | | 22e. ADDRESS
33rd st. & Univ. Pkwy, Balt. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/8/85 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO., MD. |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT 4600 LIBERTY HIGTS. AVE. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 8 1985 | | | |

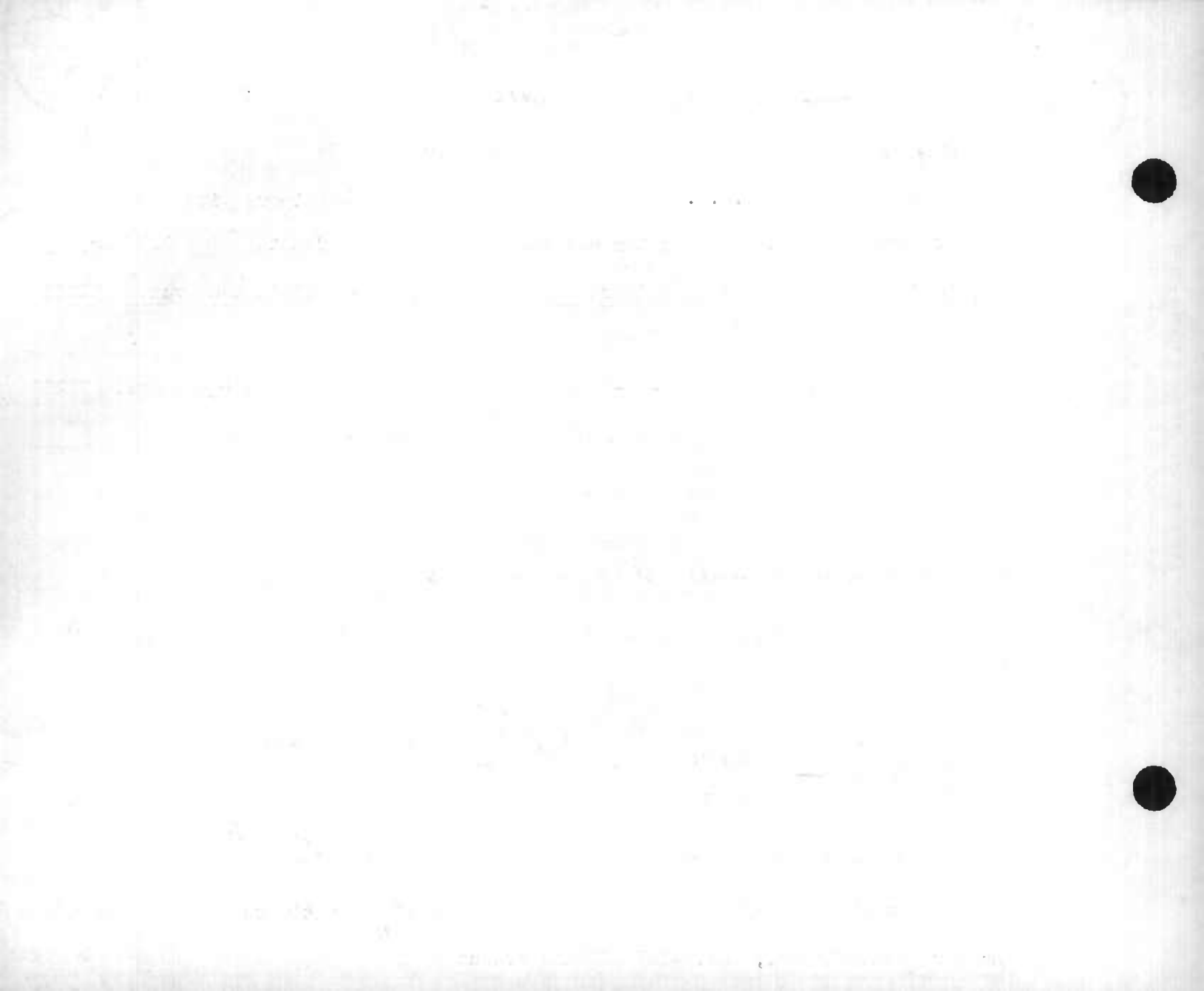
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Laurence A. Punte | | | | | 2a. DATE OF DEATH
MONTH 2 DAY 19 YEAR 85 | | 2b. HOUR
5-28 PM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH 7 DAY 3 YEAR 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Silversmith | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
 | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
440 Millington Avenue 21223 | | | |
| 14. FATHER'S NAME
FIRST August MIDDLE LAST Punte | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Agnes MIDDLE LAST Juchs | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
WW II 216-18-0505 | | 17. INFORMANT ADDRESS
Mary Ellen Punte 440 Millington Ave. 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Pneumonia & Small cell carcinoma Lung | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21i. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from 2/1 , 19 85 , to 2/19 , 19 85 , that we (we) lost
saw the deceased alive on 2/19 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, we (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ram Lal Mittal | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/19/1985 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAM LAL MITTAL | | | | | | 22e. ADDRESS
Good Samaritan Hospital
5601 Loch Raven Blvd. Baltimore, MD 21239 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME Hubbard Funeral Home, Inc. ADDRESS 4107 Wilkens Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

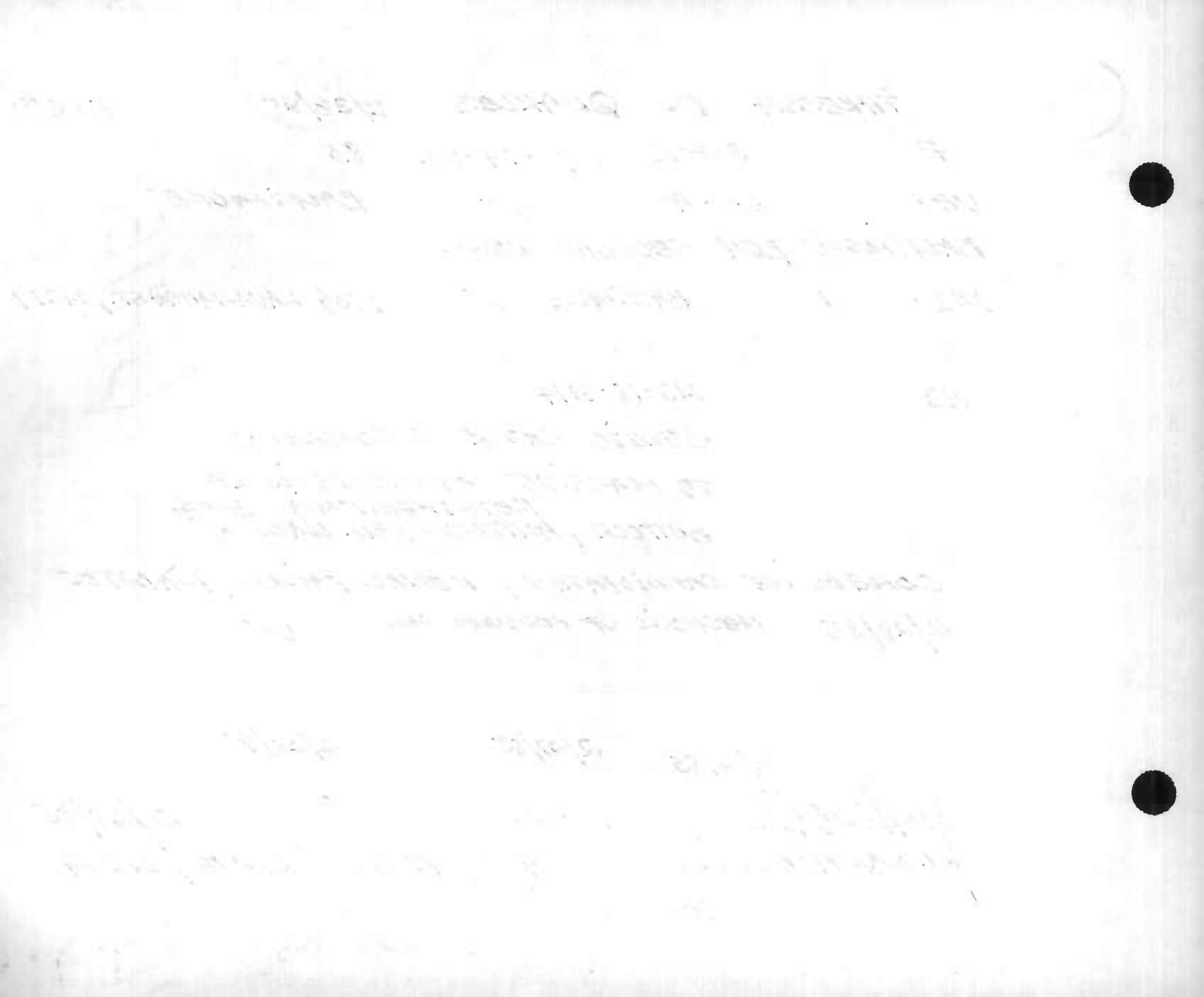
| | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THRESSA D. QUARLES | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/28/85 | | | 2b. HOUR
10:30 A. | | | | |
| 1. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-19-02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BOH SECONDS HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
1 | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1839 KAUAMUA ST., 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Junior W. Jones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY JONES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
213-18-6174 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK SECONDARY
DUE TO, OR AS A CONSEQUENCE OF (b) TO MASSIVE MYONECROSIS OF
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. RETROPERITONEAL AREA
DUE TO, OR AS A CONSEQUENCE OF (c) GLUTEAL, ANTERIOR ABD. WALL | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CONGESTIVE CARDIOPATHY, RENAL FAILURE, DIABETES | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/28/85 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NECROSIS OF ABDOMINAL WALL | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27/85 19 to 2/28/85 19, that (I) (we) last saw the deceased alive on 2/28/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. M. Hippolito | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. M. Hippolito | | | 22e. ADDRESS
4209 FREDERICK AVE, 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | | 23b. DATE
3/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | |
| 24. FUNERAL DIRECTOR
NAME
E. L. Phillips | | | ADDRESS
1721 N. Monroe St. | | | 25a. RECEIVED BY (TYPE OR PRINT) 25b. REGISTRAR'S SIGNATURE
1985 | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove color papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RUTH Harriett QUICK | | | 2a. DATE OF DEATH MONTH DAY YEAR February 23 85 | | 2b. HOUR 8:20a |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
12 24 1898 | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Florist | | 12b. KIND OF BUSINESS OR INDUSTRY
H J Quick |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
THE STATE MD | | 13b. CITY OR TOWN
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
4901 OLD COURT ROAD 21133 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John William Foster | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Regina Isenberg | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) -- | | 17. INFORMANT Randallstown ADDRESS MD 21133
Mrs. Dorothy Feaser 4901 Old Court Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASPIRATION PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD, CHF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ASCVD, CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 15, 1985 to FEBRUARY 23, 1985 , that (I) (we) last saw the deceased alive on FEBRUARY 23, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
V. Tsinberg | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTORIA TSINBERG | | 22e. ADDRESS
SINAI HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2-26-85 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City MD |
| 24. FUNERAL DIRECTOR
NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133 | | | 25a. DATE REC'D. BY REGISTRAR FEB 26 1985 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FILED

RECEIVED

FILED

APR 1964

F.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Nuchym Raczkowski | | 2a. DATE OF DEATH MONTH DAY YEAR February 23/85 | | 2b. HOUR 1:50 AM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MAY 15, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
WHOLESALE-RETAIL | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MEDEL RACZKOWSKI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHAYA CHARNEY UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
561-42-6182 | | 17. INFORMANT ADDRESS
REBECCA RACZKOWSKI 6202 GIST AVE. (21215) | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) AS above
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs
4 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stephen Marbois | | | | 22c. DATE SIGNED
2/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Marbois | | | | 22e. ADDRESS
709 Pikes Blvd. Rd. Camp Hill, PA 17012 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/24/85 | | 23c. NAME OF CEMETERY OR CREMATORY
SHOMREI MISHMERES | |
| 24. FUNERAL DIRECTOR
NAME
Sol Leunian & Bros Inc | | ADDRESS
6010 Reisterstown Rd | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE, BALTO., MD. | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2039 COTTON FIBER

CHELVIA EDWARD



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ARLINA P. RAFFEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1985 | | 2b. HOUR
7:35
P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 4, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Polisher | | 12b. KIND OF BUSINESS OR INDUSTRY
Weather Inst. Mnfr | |
| 13a. STATE
Md. | | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
1 N. Belnord Ave. 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gustav Paul Sturm | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma W. Trolenberg | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NONE, UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-03-28724 | | 17. INFORMANT
Baltimore, Md. 21224
William C. Sturm-1 N. Belnord Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA AND CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
DIGOXIN TOXICITY | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from FEBRUARY 11, 1985 to FEBRUARY 15, 1985 that (1) I saw the deceased alive on FEBRUARY 15, 1985 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (2) I did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. P. Nazemi M.D. | | | | 22c. DATE SIGNED
2/15/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ATOALLAH NAZEMI M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cen. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
John A. Moran, Inc. Funeral Home
3000 E. Baltimore St., Balto., Md. 21224 | | | | 25. REGISTRAR'S SIGNATURE
DATE REC'D. BY REGISTRAR
FEB 20 1985 | | | |

MEDICAL CERTIFICATION

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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35
1030
2
9
9

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAURIE RAINIEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 85 | | 2b. HOUR
9 22 P.M. | |
| 3. SEX
MALE | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
9 19 99 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
85 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
EDGEWOOD NSG. HOME | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Janitor | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MD. Balto. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
225 Lyndale Ave. 21236 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John T. Rainey | | | 15. MOTHER'S M maiden NAME
FIRST MIDDLE LAST
Louisa Sterling | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII Army 216-10-9114 | | 17. INFORMANT ADDRESS
Joseph M. Sabatino, 225 Lyndale Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulm. Disease, 20 years
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive C.V.D., 2 Atrial Arterio Sclerotic C.V.D., Fibillation 3-4 years | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/6/70 19 70 to 2/24 19 85 , that (I) (we) lost
saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Isaac K. Grossman MD | | | DEGREE
MD | | 22c. DATE SIGNED
2/26/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GROSSMAN MD | | | 22e. ADDRESS
3409 ROSEDALE RD. 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
2-27-85 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Balto. MD | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller | | | ADDRESS
6415 Belair RD. | | 25a. DATE REC'D. BY REGISTRAR
FEB 28 1985 | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 20. DATE OF DEATH | | 26. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) DAVID T RAISEN | | MONTH DAY YEAR
2-13-85 | | 26. HOUR
3:30 P_M | |
| 3. SEX
M ALE | 4. RACE
W HITE | 5. DATE OF BIRTH
MONTH DAY YEAR
8-14-11 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONN. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
City OF BALTIMORE MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hosp. of BALTO. | 12a. USUAL OCCUPATION
NATIVE JAMES PROGRAM | 12b. KIND OF BUSINESS OR
INDUSTRY
U.S. GOV'T | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | 13b. CITY OR TOWN
BALTO | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
3302 Greenvale Rd | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WOLF | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE BOGDANOFF | | 21208 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES. WWII ARMY | | 16b. SOCIAL SECURITY NO.
045092370 | | 17. INFORMANT
MRS. VIRGINIA RAISEN
3302 GREENVALE RD. (21208) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CANCER
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SECONDS
MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/13/85 , 19____, to 2/13/85 , 19____, that (1) (we) last saw the deceased alive on 2/13/85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Donald R. Taylor M.D. | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R. TAYLOR | | 22e. ADDRESS
SINAI Hosp. Dept. of Medicine | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL/ REMOVAL | 23b. DATE
FEB. 17, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
MT. SINAI MEM. PARK | 23d. LOCATION
CITY OR TOWN COUNTY STATE
NEW HAVEN CONN. | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS. | | ADDRESS
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
Jane Wadsworth | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) STELLA M. RAKOWSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 27, 1985 | | 2b. HOUR
MIN
12:26 | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
10-4-1902 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
CHURCH HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE
2616 FOSTER AVE 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK KUREK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JADWIGA KOPERA | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
ADAM RAKOWSKI | | 17. INFORMANT
ADDRESS
2616 FOSTER AVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) COPD WITH ACUTE RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT LOWER LOBE PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 70a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 12, 1985 to February 27, 1985 , that (I) (we) lost sight of the deceased alive on February 27, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (true) (did not view the body after death) | | | | | | |
| 22b. SIGNATURE
<i>W. Impagliatelli</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. IMPAGLIATELLI, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL
100 N. BROADWAY, BALTO., MD 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
MARCH 2, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. |
| 24. FUNERAL DIRECTOR
RAYMOND L. KACZOROWSKI | | 25a. DATE RECD. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Gandall</i> | | |

BP

NOT RECORDED

RECEIVED

[Faint, illegible handwriting throughout the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES Ellsworth RANKIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 4, 1985 | | | 2b. HOUR
2:45AM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Meat Processing | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7200 Dunmanway 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Rankin | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leannah Martin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217/01/0582 | | 17. INFORMANT
ADDRESS
Dolores H. Hampshire 8703 Roper Rd. 21234 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ISCHEMIC HEART DISEASE, DIABETES MELLITUS | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this <input checked="" type="checkbox"/> hospital) attended the deceased from JANUARY 9, 1985 to FEBRUARY 4, 1985 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on FEBRUARY 4, 1985 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Paul Gormley</i> | | | | | DEGREE
MD | | | 22c. DATE SIGNED
2/4/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL GORMLEY | | | | | 22e. ADDRESS
CHURCH HOSPITAL
100 NORTH BROADWAY 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
2/6/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mt. Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | | 25a. DATE REC'D BY REGISTRAR
FEB 6 1985 | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

BP

93817 MD100 2002

CHIEF W. DOW



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

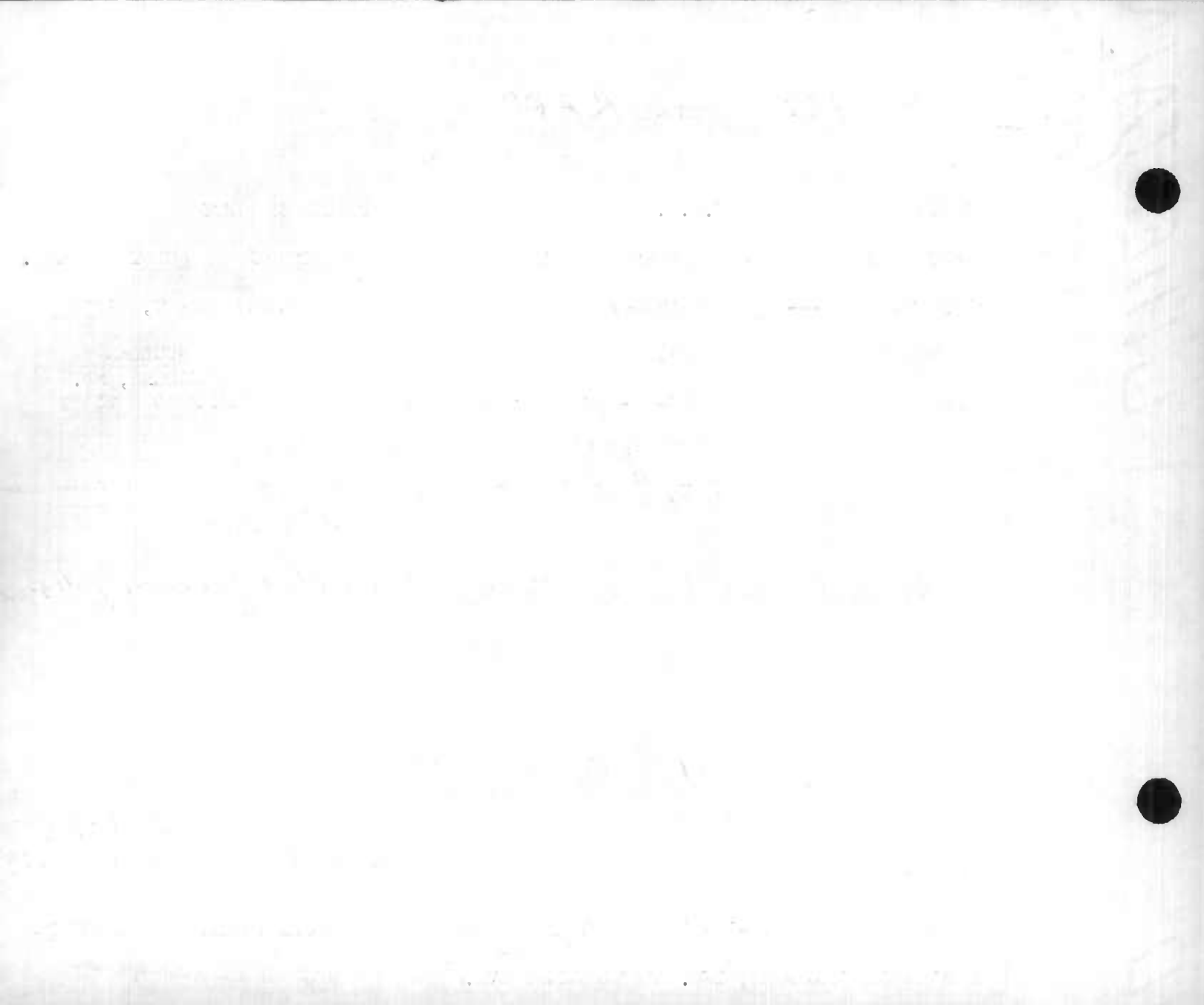
| | | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED CATHERINE RAPP | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-11-85 | | | 2b. HOUR
5-10 P.M. | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 17 10 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING MFG. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY RAPP | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET SCULLEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-03-2704 | | 17. INFORMANT
ADDRESS PASADENA, MD.
WILLIAM SNYDER 8458 CHURCH ROAD 21122 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Renal failure Chronic Obstructive pulmonary disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-14-85</u> , 19 <u>85</u> , to <u>2-11-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-10-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>S. Baskaran</u> | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
2-11-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. BASKARAN M.D. | | | | | 22e. ADDRESS
3455 Wilkens Ave Baltimore 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
02-15-85 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Jane Davidson-Randall</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EUGENE RAY | | | | | | | | | | 2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2 15 19 85 | |
| 3. SEX male 4. RACE Black 5. DATE OF BIRTH MONTH 3 DAY 22 YEAR 49 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD MONTH 2 DAY 15 YEAR 19 85 2d. HOUR 9:45 AM | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2035 E. North Ave. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2035 E. North Ave. 21213 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Alonze MIDDLE Ray LAST Estelle 15. MOTHER'S MAIDEN NAME FIRST Estelle MIDDLE Smith LAST Smith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 216-48-3062 | |
| 17. INFORMANT ADDRESS Jacqueline Ray 2035 E. North Avenue | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: Cardiomyopathy
IMMEDIATE CAUSE (a) Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | |
| 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon DATE SIGNED 2-15-85 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 2/22/85 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans Eastview Memorial Pk. 23d. LOCATION CITY OR TOWN Baltimore COUNTY Harford STATE Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. ADDRESS 1101 E. North Ave 25a. DATE REC'D. BY REGISTRAR FEB 19 1985 25b. REGISTRAR'S SIGNATURE John A. Dixon | | | | | | | | | | | |

20% COTTON BLEND

GREEN MOUNTAIN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|--|---|---|----------------------------------|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Roswell Ray, Sr. | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2/ 16/ 19 85 | | 2b. HOUR
6:21 P M | | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 1 35 | 6. AGE (IN YEARS)
LAST BIRTHDAY
49 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN | 7c. DATE PRONOUNCED DEAD
2/ 16/ 19 85 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2208 Tucker Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21207 2208 Tucker Lane Apt. A-6 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Robinson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hilda Ray | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
219-30-4041 | | 17. INFORMANT
ADDRESS
Jean E. Ray 2208 Tucker Lane A-6 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATTO TO THE TERMINAL DISEASE OR CONDIOTN GVLN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
2/17/85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

QUART MORTON 1003

2000-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

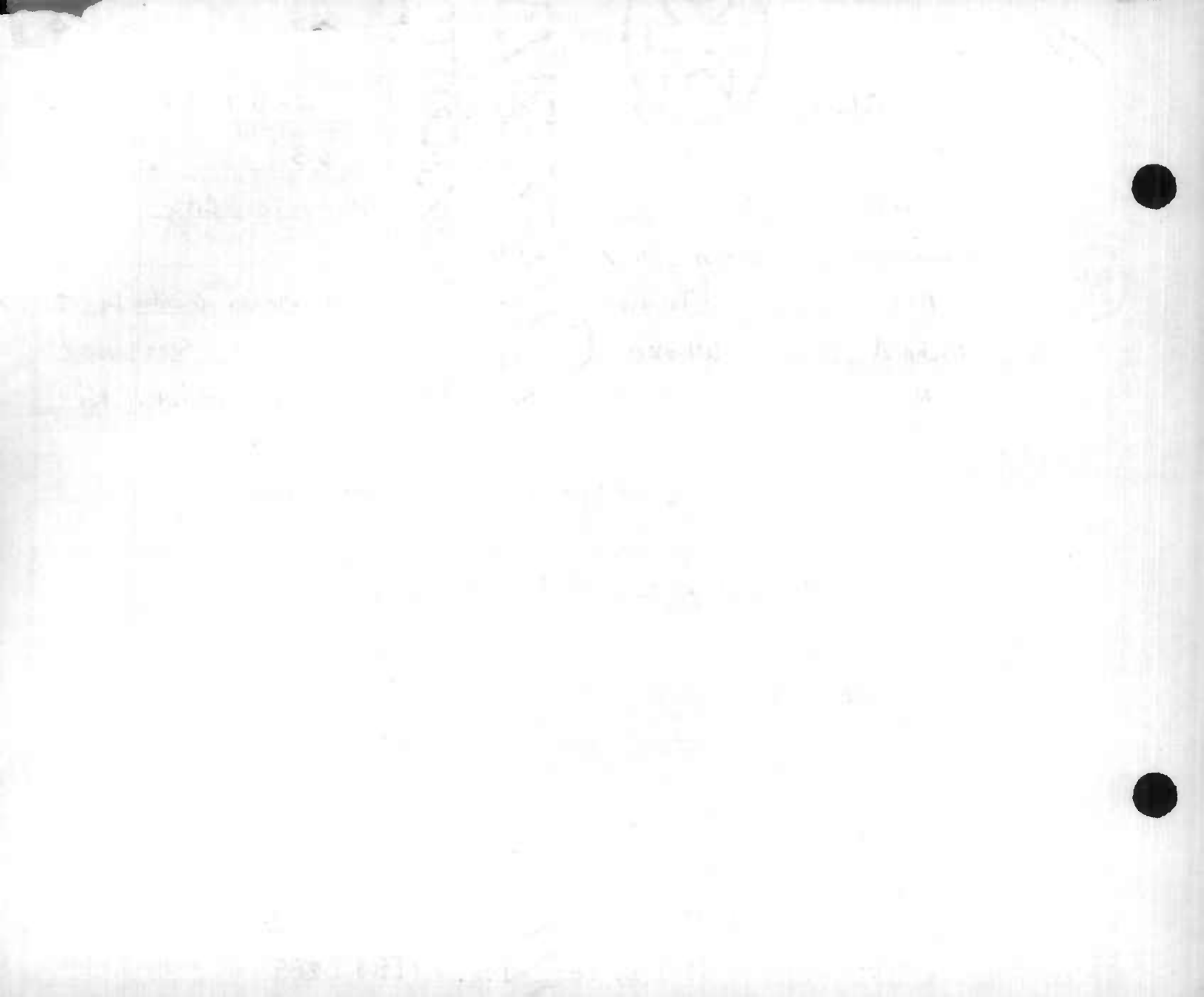
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 4715 | | | | | | | | | |
|---|------|---|------|---|--|-----------------|--|------------------|--|--------|------|-------|------|
| 1. DECEASED NAME
(TYPE OR PRINT) Gladys Irene Rayner | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-07-85 | | | | | | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 12 21 | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. <table border="1"><tr><td colspan="2">IF UNDER 1 YEAR</td><td colspan="2">IF UNDER 24 HRS.</td></tr><tr><td>MONTHS</td><td>DAYS</td><td>HOURS</td><td>MIN.</td></tr></table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | MONTHS | DAYS | HOURS | MIN. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | |
| MONTHS | DAYS | HOURS | MIN. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Med Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Whalen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Smallwood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Pearl Coleman 401 Nottingham Rd | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circumferential aortic aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (c) Pharyngeal Aneurysm | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pharyngeal Aneurysm | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-2 19 85 , to 2-7 19 85 , that (I) (we) lost saw the deceased alive on 2-7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Sharon J. Brown DEGREE | | | | 22c. DATE SIGNED 2-9-85 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brown | | | | 22e. ADDRESS 844 Ch. Carey St. 21217 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H | | ADDRESS 1101 E. North Ave. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR FEB 11 1985 | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 1 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH T. READING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 09 85 | | 2b. HOUR
5:15A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
January 14, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | 7. UNDER 1 YEAR
MONTHS DAYS
8. UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balt. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Beautician | 12b. KIND OF BUSINESS OR INDUSTRY
Beauty shops | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
P.G. | | |
| 13c. CITY OR TOWN
College Park | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
4800 Calvert Road 20740 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Y. Reading Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith Isabell Rhine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579 16 3918 | | 17. INFORMANT
William R. Reading
ADDRESS
4800 Calvert Road College Park, Md. 20740 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cerebral vascular disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

senile dementia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

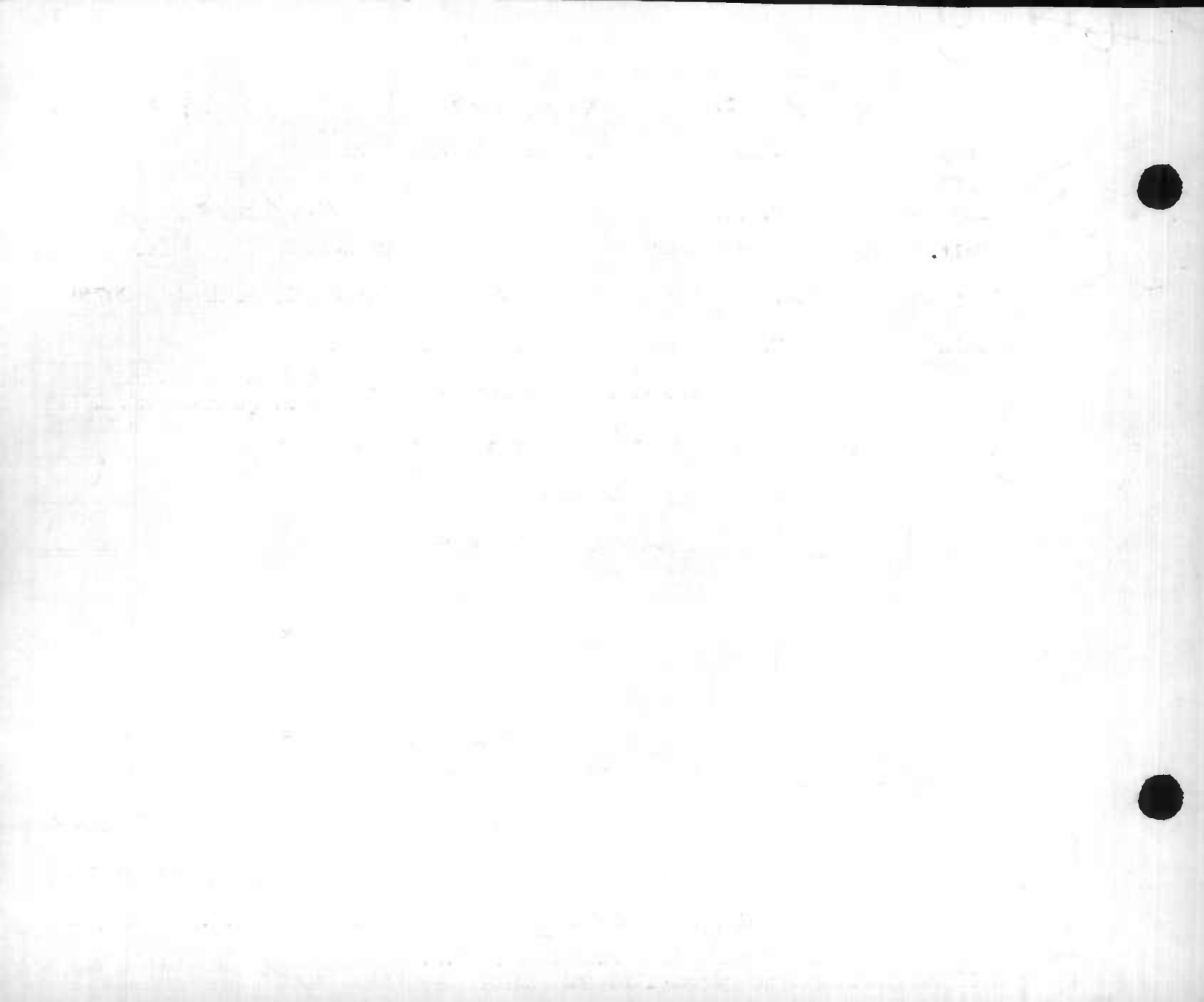
| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8 19 85 , to 3/9 19 85 , that (I) (we) last saw the deceased alive on 3/8 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang | | DEGREE
M.D. | | 22c. DATE SIGNED
3/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG | | 22e. ADDRESS
Bon Secours Hospital | | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/12/85 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. Maryland |
|---|-----------------------------|--|---|

| | | |
|--|---|---|
| 24. FUNERAL DIRECTOR
NAME
Francis Gasch's Sons Funeral Home P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781 | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | 25b. REGISTRAR'S SIGNATURE
Greta T. ... |
|--|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as true, it shows only injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PAULINE M REDDICK | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 2-4-85 19 | | 2b. HOUR M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD
2-4-85 19 2:23P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
630 S. Paca Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
630 S. Paca St. 21230 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Moses Miller | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Taylor | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mary J. Bridges 210 S. Paca St. (29) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
metastatic carcinoma of colon | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margaret A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-6-85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2-9-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MChas.A. Rice FSPA 1300 Eutaw Pl. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

2029 COTTON FIBER

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ephriam F. REDMON | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEB 8 1985 | | | 2b. HOUR
early a.m. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 28 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6106 DANVILLE AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
GUARD | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
W P REDMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DORA FOSTER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WW II 237-14-9864 | |
| 17. INFORMANT
MARY REDMON | | ADDRESS
6106 DANVILLE AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest or Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(b) R/O Myocardial Infarction (chest pain several hours before death)
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension / Thrombocytosis idiopathic
Estimated time of death at least 3 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Chronic bronchitis / chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 7 1985, to Jan. 7 1985, that (I) (we) lost saw the deceased above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Allen M. Friedman MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/8/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen M. Friedman MD | | 22e. ADDRESS
2112 Dundalk Ave, Balt. 21222 Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. CITY MD. | |
| 24. FUNERAL DIRECTOR
NAME
CONNELLY FUNERAL HOME OF DUNDALK | | ADDRESS | | 25a. DATE OF REGISTRATION
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John Anderson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100%

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|------------------|--|---|---|----------------------------------|---|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Donna Marie Redmond | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2/27/ 19 85 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
May 23, 1960 | 6. AGE (IN YEARS)
LAST BIRTHDAY
24 YRS. | 7. IF UNDER 24 YRS.
MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
2/ 27/ 19 85 | | 2d. HOUR
11:25 A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. CITY OR TOWN
Mechanicsville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William J. Redmond | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Wm. J. Redmond | | | | | | | | | | ADDRESS
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY?
HEAD ONLY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR
7:30 M. 2/ 23/ 19 85 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self inflicted wound | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
alley (rear of) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
500 S. East Ave., Balto. City, Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described herein and in my opinion death resulted from:
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gregory R. Kauffman</u> M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 2/28/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
Mar. 2, 1985 | |
| 23c. NAME OF CEMETERY OR CREMATORY
All Faith Cemetery | | | | | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Charlotte Hall St. Mary's | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. Clarke Mattingley Leonardtown, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Jelia Davidson-Rendall | | | | | | | | | | Md. | |



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INTERVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE P. LAST REED | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 85 | | | 2b. HOUR
5 ¹⁵ AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 19 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY Baltimore, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
3309 Avondale | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3309 AVONDALE 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob Wicks | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Madorah Wicks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
212-20-9359 | | 17. INFORMANT
ADDRESS
Madorah Harrell 3309 Avondale Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEVERE DEHYDRATION</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE HYPOTENSION</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>UTI with Sepsis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5</u> , 19 <u>85</u> , to <u>2-18</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2-18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Roberta Tabaka | | | | | | DEGREE
DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-18-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERTA TABAKA DO | | | | | | 22e. ADDRESS
SINAI HOSP OF BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Wm C March F/H Inc. 1101 E North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Rendall | | |



BP_____

DHMH - 17

(VR A15 ME (5))

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|--|--|--|--|--|--|---|--|
| #5, FilmG602 4/4/85 km | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 2 5 | | 0 4 7 2 1 | |
| 1- STATE REGISTRAR | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| PATRICK R. REGAN REAGAN | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH (MONTH DAY YEAR) | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | white | | 4 19 1976 | | 38 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Pa. | | U. S. A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 405 S. Caton Ave. | | Computer Programmer Computer Co | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md | | | | Baltimore | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Cyril G. Regan | | Ann Lazor | | 165-38-1543 | | 4231 Kota Ave., Harrisburg, Pa. 17110 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 18c. CITY OR TOWN | | 18d. STATE | |
| No | | 165-38-1543 | | Baltimore | | Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20. DATE OF OPERATION | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Smoke inhalation and thermal injury</u> | | | | | | | |
| 8902 | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | |
| (b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| house | | 405 S. Caton Ave., Balto. | | Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | |
| ACTUAL SIGNATURE | | M.D. Assistant | | MEDICAL EXAMINER | | 2-22-85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Ann M. Dixon, M.D. | | ADDRESS | | 111 Penn St., Balto. Md. 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 3-1-85 | | St. James Catholic Cem. | | Pleasant Mount, Pa | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 1334 N 2ND ST HARRISBURG, PA | | 17102 | | MAR 04 1985 | | Julia Davidson | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|---|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ESTHER VERONICA REICHERT | | | | 2a. DATE OF DEATH MONTH DAY YEAR February 7, 1985 | | 2b. HOUR 7:47A M | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 06 26 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE MARYLAND | 13b. COUNTY --- | 13c. CITY OR TOWN BALTIMORE | | 13e. STREET ADDRESS / ZIP CODE 2657 DULANY STREET, 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DANIEL STEINACKER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH ABELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-26-6331 | | 17. INFORMANT ADDRESS ELEANOR RIDGELL 2655 DULANY STREET, 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERGLYCEMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) UREMIA | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min.
1 week
1 week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, HISTORY OF RECENT STROKE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 29, 1985 to February 7, 1985 , that (I) (we) last saw the deceased alive on February 7, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE C.S. Ramsey DO. DEGREE | | | | 22c. DATE SIGNED 2/7/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.S. Ramsey, M.D. | |
| 22e. ADDRESS CHURCH HOSPITAL | | | | 22f. ADDRESS 100 N. BROADWAY, Balto, MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 02-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 11 1985 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|--|--|---|--|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT F REID | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 11 85 | | | | 2b. HOUR
6:25a <small>M</small> |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
9 11 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Veterans Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OR WORKING LIFE)
Maintenance Housekeeping | | 12b. KIND OF BUSINESS OR INDUSTRY
Baltimore Hospital City | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3601 Cedardale Rd. Baltimore, Maryland 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Phineas Reid | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary A. Sydner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | | | | |
| 16b. SOCIAL SECURITY NO.
116-07-7995 | | 17. INFORMANT ADDRESS
Mary C. Reid Baltimore, Maryland 21215 | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Right Middle Lobe Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) Pseudo aneurysm in descending thoracic aorta graft
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
12/1/84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hopkins Dissecting desc. Thoracic aorta | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 7 19 85 to FEBRUARY 11 19 85 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 11 19 85 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Scott A. Berger MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/11/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott A. Berger MD | | | 22e. ADDRESS
Lock Raven VMC BALTIMORE | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/15/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Veteran | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL HOME OR OTHER ORGANIZATION NAME
Nutter & Sons | | 24b. ADDRESS
2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | |

MEDICAL CERTIFICATION

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|-----------|-------------------------|------------|--|
| Male | Black | 8 11 1911 | VS |
| Virginia | U. S. A. | | |
| Baltimore | Veterans Medical Center | Honorable | Baltimore |
| Baltimore | Baltimore | X | No. Baltimore, Maryland 21215 |
| Chinese | Male | 11-07-1911 | VS |
| Yes | 11-07-1911 | Male | 3801 Cedarvale Road
Baltimore, Maryland 21215 |

General Home Inc. 3801 Gwynne Falls Parkway
Baltimore, Maryland 21215
2/12/1982 Garrison Forest Veterans
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|--|----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVELYN B. REILLY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 85 | | 2b. HOUR
3:50 A.M. |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 29 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b CITIZEN OF WHAT COUNTRY?
U. S. A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Worker for Disabled Vets. | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard T. Brawn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE EAST
Virgie Hammock | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
W.W.II 218-07-9807 | | 17 INFORMANT
813 N. Chapelgate Lane-Balto., Md. #21229 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) End Stage Heart failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Ischemic heart disease with Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5:PM 2/17 1985 to 3:5AM 2/18 1985 , that (he)(we) last saw the deceased alive on 5PM 2/17 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Aril P. Imam | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARIL P. IMAM | | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vets. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Md. |
| 24. FUNERAL DIRECTOR
NAME
G. L. Schwab | | | | 5151 Balto. Nat'l. Pike
ADDRESS
#21229 | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 |
| 25b. REGISTRAR'S SIGNATURE
G. L. Schwab | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove cause of death, age, and date of death. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of price.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SARA H J. REINSFELDER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 15, 1985 | | | 2b. HOUR
4:41 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2-24-1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2032 E. Lanvale Street-21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Lawson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
212-74-4852
215-09-4801B | | 17. INFORMANT
ADDRESS
Mr. Joseph P. Reinsfelder - 2032 E. Lanvale St. 21213 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
min | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 85 , to 2/15 , 19 85 , that (I) (we) last saw the deceased alive on 2/15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Jonathan Israel | | | 22c. DATE SIGNED
2/15/85 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jonathan Israel | | | | |
| 22e. ADDRESS
N. Wolfe St, Balt MD 21205 | | | 22f. ADDRESS
N. Wolfe St, Balt MD 21205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc-6415 Belair Rd.-21206 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 2 6

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED S. RETTMAN | | | 2a. DATE OF DEATH
FEBRUARY 27, 1985 | | 2b. HOUR
5:00 PM | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
3/29/13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HSWK | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES J. PETITT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET S. BISHOP | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212 24 1866 | | 17. INFORMANT
ADDRESS
JANET SHAFFER 9714 CONMAR RD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF PANCREAS TWO MONTHS
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (if this hospital attended the deceased from FEBRUARY 14, 1985 to FEBRUARY 27, 1985 , that (I) (we) last saw the deceased alive on FEBRUARY 27, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Adoracion B. Paulino | | DEGREE
MD | | 22c. DATE SIGNED
1985 FEBRUARY 27 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ADORACION PAULINO B | | 22e. ADDRESS
100 NORTH BROADWAY
BALTIMORE, MARYLAND 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN CEM | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
J.G. CONNELLY 300 MACE | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

11/13/13

11/13/13

11/13/13

11/13/13

11/13/13

11/13/13

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11/13/13

11/13/13

11/13/13

11/13/13

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 2 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEAN W. REUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 4 85 | | 2b. HOUR
10:30 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 12, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scotland | 7b. CITIZEN OF WHAT COUNTRY?
British | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | | 13b. COUNTY
USA | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Walker | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Mc Alpine | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
214 74 1531 | | 17. INFORMANT ADDRESS
Henry W. Reus 6312 Banbury Road 21212 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive intracerebral hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
22 hrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>2/3</u> , 19 <u>85</u> , to <u>2/4</u> , 19 <u>85</u> , that (1) (we) lost saw the deceased alive on <u>2/4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Bernita C. Taylor</u> | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/4/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNITA TAYLOR, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
02/06/85 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home, 3631 Falls Rd. 21211 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 7 1985 <u>John Davidson</u> | | | |

37
49
35
300

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

INFORMAL COPY

DATE: 10/10/1964

TO: J. Edgar Hoover

FROM: J. Edgar Hoover



SUBJECT: [Illegible]

RE: [Illegible]



10% COTTON FIBER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 2 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Helen B. Rewers | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 5, 1985 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 2, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 2+ HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6211 The Alameda (Residence) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Hochschild | | 12b. KIND OF BUSINESS OR INDUSTRY
- Kohn |
| 13a. STATE
Maryland | 13b. COUNTY
 | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6211 The Alameda 21239 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph W. Pluhar | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara C. Buchta | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No
(IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
213-26-1824 | | 17. INFORMANT ADDRESS
Frank H. Rewers 6211 The Alameda 21239 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Probable Cerebral HemorrhageAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Hours**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

Severe Thrombocytopenia**2 months**

DUE TO, OR AS A CONSEQUENCE OF

(c)

aplastic Anemia**2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **Jan 23, 1985** to **Feb 5, 1985**, that (I) (we) last saw the deceased on **Jan 23, 1985**, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE

Charles Padgett

DEGREE

MDATTENDING
PHYSICIANMEDICAL
DIRECTOR ☒STAFF
PHYSICIAN ☐

22c. DATE SIGNED

2/6/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Charles Padgett M.D.

22e. ADDRESS

5601 Loch Raven Blvd. Baltimore, Md.23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) **Burial**23b. DATE
Feb 8 198523c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial23d. LOCATION
CITY OR TOWN **Baltimore** COUNTY **Maryland** STATE **Maryland**

24. FUNERAL DIRECTOR

NAME
Leonard J. Ruck, Inc. Baltimore, Maryland

ADDRESS

25a. DATE REC'D. BY REGISTRAR **FEB 7 1985**25b. REGISTRAR'S SIGNATURE
Charles Padgett

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 1.

February 2, 1962

Alaska

U.S.A.

Alaska

to

Nov. 2, 1961

U.S.A.

Alaska

February 10

x

U.S.A.

Alaska

Nov. 2, 1961 - 1962

Alaska (Alaska)

Alaska

Nov. 2, 1961 - 1962

x

Alaska

Alaska

Alaska

U.S.A.

Alaska

Alaska

U.S.A.

Alaska

Nov. 2, 1961 - 1962

Alaska

Alaska

Alaska (Alaska)

Alaska (Alaska)

Alaska (Alaska)

Nov. 2, 1961

Alaska

U.S.A.

Alaska

Nov. 2, 1961 - 1962

Alaska

Alaska

U.S.A.

Alaska

U.S.A.

Alaska

Alaska (Alaska)

1271

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 2 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William Burnett Reynolds | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 11 1985 | | | 2b. HOUR
00 14 M | | | | |
| 3 SEX
male | | 4 RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 18, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
installation | | 12b. KIND OF BUSINESS OR INDUSTRY
carpet | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
626 Beach Dr. 21403 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter D. Reynolds | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel N. Dabny | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes 52-55 | | | | 16b. SOCIAL SECURITY NO.
578-42-2878 | | 17. INFORMANT
ADDRESS
Patricia Reynolds same as 13e. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive hemoptysis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>one hr</u>
<u>two hrs</u>
<u>3 hrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>α1 antitrypsin deficiency</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>14 Jan</u> 19 <u>85</u> to <u>11 Feb</u> 19 <u>85</u> , that (I) (we) <u>do</u> saw the deceased alive on <u>11 Feb</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Richard A. Lange</u> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
11 Feb 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Richard A. Lange</u> | | | 22e. ADDRESS
<u>The Good Samaritan Hospital</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veterans Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | ADDRESS
12 Ridgely Ave. Annapolis, Md. 21401 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>L. Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been filed by the attending physician and completely filled in by the funeral director, who should be detached for use as the burial-transit permit. When possible, remove carbon papers. Page and 2 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18, a copy of the certificate should be filed with the State Dept. of Health and Mental Hygiene.

RECEIVED
JAN 10 1960
U.S. DEPT. OF JUSTICE

RECEIVED
JAN 10 1960
U.S. DEPT. OF JUSTICE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 3 0

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARGARET Ellen RHUDY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 24, 1985 | | 2b. HOUR
01:08am |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 13, 1985 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4320 Claireway Avenue 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
late John Scobey | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
late Hettie King | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217 07 7925 D | 17. INFORMANT ADDRESS
21044 Robert Rhudy 10300 Night Mist Court 21044 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs
24 hrs
10 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Respiratory Failure; Acute Renal Failure; Stroke | | | | | |
| 19a. DATE OF OPERATION
12/15/84 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 12, 1984 to February 24, 1985 , that I (we) last saw the deceased alive on February 24, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Walter M. Morgan III MD | | DEGREE
MD | | 22c. DATE SIGNED
2/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter M. Morgan III MD | | 22e. ADDRESS
Johns Hopkins Hosp. Bldg | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
Feb 26, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balto. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Harry H Witzke 4112 Columbia Rd Ellicott City | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by a physician. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Do not sign, stamp, or write on page 4 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other information, send the medical certificate to the medical examiner.

BP

RECEIVED
FEBRUARY 22 1966

22 00



20% POLYMER

20% POLYMER

20% POLYMER

20% POLYMER

20% POLYMER

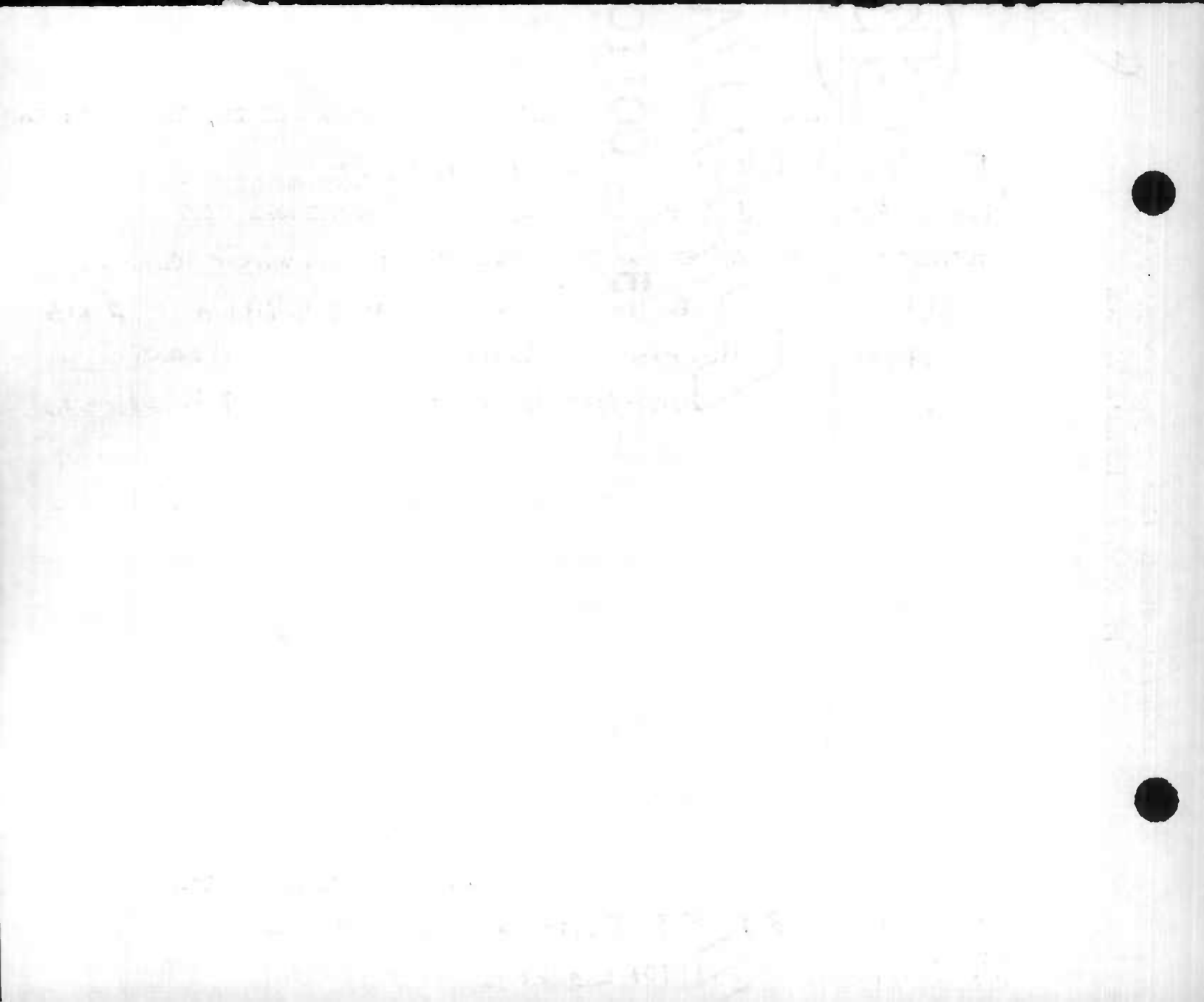
20% POLYMER

RELEASED AS NON MED BY DR KORELL OF THE
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | 8 5 0 4 7 3 1 | |
|--|--|---|--|---|--|--|---|
| 1- FOR
STATE
REGISTRAR | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CLARA | | MIDDLE
RICE | | LAST | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 10 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Country
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Factory Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Canning | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Harris | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie Jenifer HARRIS | | 13e. STREET ADDRESS / ZIP CODE
1123 N. Milton 21213 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
21207-9322 | | 17. INFORMANT
Mary E. Robinson | | ADDRESS
1620 E. Belvedere Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Remote history of ovarian cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>20 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>85</u> , to <u>2/25</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2/25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Robert L. Redner MD</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert L. Redner MD | | 22e. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-1-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
JOS. A. MORTON & Sons | | | | ADDRESS
1701 LAWRENCE | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Lisa Davidson-Randall | | | |

BP _____



1- STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Estelle ELIZA Elizabeth | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 2 11 19 85 | | 7b. HOUR
M | |
| 3 SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1-10-42 | 6. AGE (IN YEARS)
LAST BIRTHDAY
43 YRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 15 19 85 | 7d. HOUR
A M
11:46 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1131 N. Monroe St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Md. | | | | | |
| 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clem Coleman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Coleman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
st.
Joseph Sydnor JR. 1517 N. Monroe | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute alcohol intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
2-15-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sun Flower Cem. | |
| 24. FUNERAL DIRECTOR
NAME
Chas. A. Rice FSPA | | ADDRESS
1300 Eutaw Pl., | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

07/84
25M

BP 1058
DHMH - 17
(VR A15 ME (5))

20% COTTON EIDER

WIND

WIND



RELEASED AS NON-MED DR. ANNE DIXON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be held.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 5 0 4 7 3 3 | |
|--|--|---|--|---|------------------------------------|--|--|--|----------|---|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| WILLIAM Kent RICE, JR. | | | | | | FEBRUARY 26, 1985 | | | 10:24 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | FEB. 23 1985 | | — YRS. | | MONTHS 3 | | DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | | | | NONE | | — | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE COUNTY | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6544 B HAWTHORNE DRIVE/21040 | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| 14. FIRST MIDDLE LAST | | | | | | 15. FIRST MIDDLE LAST | | | | | |
| WILLIAM KENT RICE | | | | | | REBECCA ANN BUNCH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT ADDRESS | | | | | |
| — NO | | | NONE | | | WM. K. RICE, 6544 B. HAWTHORNE DR., EDGEWOOD, MD. 21040 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>HYPOTENSION</u> | | | | | | | | | | 30 MIN. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>CONG. CARDIAC SURG. REPAIR</u> | | | | | | | | | | 4 HRS. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>CONG. CARDIAC ANOMALIES</u> | | | | | | | | | | 4 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2/26/85 | | | CYANOSIS | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>85</u> , to <u>2/26</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| | | | | | | M.D. | | 2/26/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| FONGER | | | | | | J. H. H. 601 N. WOLFE ST. BALTO. MD. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| REMOVAL/CREMATION | | | FEB. 28, 1985 | | CRATIN AND FERRIS | | WEST CHESTER, CHESTER, PENNA. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | |
| TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3369 | | | | | | MAR 4 1985 | | | | | |

MEDICAL CERTIFICATION

99

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|--|---|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Herbert S. Richardson, Jr. | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-14 1985 | | 2b. HOUR
2:10 a. m. | | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR 4 28 66 | 6. AGE (IN YEARS)
LAST BIRTHDAY 18 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2-14 1985 | | 2d. HOUR
a. m. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS
1814 Ashburton St. 21216 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herbert S. Richardson, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fidelia Turner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
212-86-9621 | | 17. INFORMANT
ADDRESS
Fidelia Richardson 1814 Ashburton | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of Chest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:18xx 2-14 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject was shot. | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
on street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1700 blk. Ashburton St., Balto., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> M.D. Assistant | | | | | | TITLE (SPECIFY)
Assistant | | DATE SIGNED 2-14-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

20% COTTON FIBER

MADE IN U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 3 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SHIRLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-10-85 | | | 2b. HOUR
4 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 25, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVINDALE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ADMN. ASSISTANT | | 12b. KIND OF BUSINESS OR
INDUSTRY
NATIONAL LABOR RELATIONS BOARD | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FATHER'S NAME
FIRST MIDDLE LAST
MEYER SCHWARTZ | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PAULINE ALLISON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-03-1485A | | 17. INFORMANT
MR. JULIUS RICHMOND
2431 FOREST GREEN RD. BALTO., MD 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) SEVERE PARKINSONISM
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WK YEARS. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
MULTIPLE DECUBITUS ULCERS. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-24-85 to 2-10-85 , that (I) (we) lost
saw the deceased alive on 2-10-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
B. ZAW-LIN, M.D. | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2-10-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. ZAW-LIN, M.D. | | | | | | 22e. ADDRESS
Levinite Geriatric Ctr
BALTO 21215 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
FEB. 11, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
BNAI ISRAEL | | 23d. LOCATION
BALTIMORE COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "While at work" or "Not while at work," the medical examiner must be notified of the nature of the event.

BP



NOT MAILABLE

POSTAGE WILL BE PAID BY ADDRESSEE

Respectfully,
James

Deborah

10-10-92

Thank you for the information
provided regarding the
situation in the
community.

SEE PAGE 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 3 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ellen Marie Ridgaway | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 7 1985
2b. HOUR
12:30 P.M. | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 7, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Keswick Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary
12b. KIND OF BUSINESS OR INDUSTRY
Home Life | |
| 13a. STATE
Maryland | 13b. COUNTY
-- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
Glen Allen Avenue 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Ridgaway | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia M. Day | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
212-01-0517 | | 17. INFORMANT
ADDRESS
Julia M. Ridgaway Athol Avenue
Baltimore, Md. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
27 YRS. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 Aug 1970 to 7 Feb 1985, that (I) (we) last saw the deceased alive on 7 Feb 1985, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Aubrey Richardson M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
7 Feb 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Aubrey Richardson M.D. | | 22e. ADDRESS
Keswick Nursing Home, Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/9/85 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke
1630 Edmondson Avenue, Catonsville, Md. 21228 | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | 25b. REGISTRAR'S SIGNATURE
Richardson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes," it shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

288 1 1837

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>ANDREW</u> MIDDLE <u>JACKSON</u> LAST <u>Riffe</u> <u>RIFE</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>2/17/1985</u> <u>2</u> <u>17</u> <u>85</u> | | 2b. HOUR
<u>4³⁰</u> <u>A</u> <u>M</u> | |
| 3. SEX
<u>M</u> Male | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>Sept. 12,</u> <u>1911</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>73</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Kentucky</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>univ of Maryland</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Crane Operator</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Steel Mfrgr.</u> |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Garrett</u> | 13c. CITY OR TOWN
<u>Oakland</u> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>Richard</u> MIDDLE <u>Tynner</u> LAST <u>Riffe</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>CORA</u> MIDDLE <u>Kelly</u> LAST <u>Kelly</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
<u>No</u> | |
| 17. INFORMANT
<u>Neva C. Riffe (Wife)</u> | | ADDRESS
<u>(Same as 13e)</u> | | 18. SOCIAL SECURITY NO.
<u>236-09-2845</u> | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>squamous cell lung cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>85</u> , to <u>2/17</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/17/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>H PARNER</u> | | 22e. ADDRESS
<u>UMCC 22 S. Green St. Balto, Md.</u> | | | |

| | | | |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | 23b. DATE
<u>2/21/1985</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mullins Cemetery</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Beefhide Kentucky</u> |
| 24. FUNERAL DIRECTOR
NAME
<u>Walter Brooks Bradley Inc., Dundalk, Md. 21222</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 19 1985</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and the medical examiner's report will be filed with this certificate.

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
02-27-85 | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | 23d. LOCATION
CITY OR TOWN
ELKCRIDGE
COUNTY
HOWARD
STATE
MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC.
ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985
25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

| | |
|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC SQUAMOUS CELL LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTHEROSCLEROTIC CARDIOVASCULAR DISEASE + 5
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 MIN
> SEVERAL MONTHS
YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (in this hospital) attended the deceased from 2/20 19 85 to 2/24 19 85 , that (I/we) last saw the deceased alive on 2/24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
<i>Christina Van Lonkhuyzen</i>
DEGREE
MD | 22c. DATE SIGNED
2/24/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINA VAN LONKHUYZEN | 22e. ADDRESS
22 S. GREENE ST.
BALTIMORE, MD 21201 |

| | | | | | |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
(Peggy) SYLVIA G. RIGGINS | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 24 85 | | 2b. HOUR
542A |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH MONTH DAY YEAR
5 28 18 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
HALETHORPE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4422 LINDEN AVE./21227 | |
| FATHER'S NAME FIRST MIDDLE LAST
WILLIAM F. KIRBY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DOROTHY M. EDER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
218-36-1379 | 17. IF FORMANT ADDRESS
MULFORD B. RIGGINS 4422 LINDEN AVENUE, 21227 | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8504738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

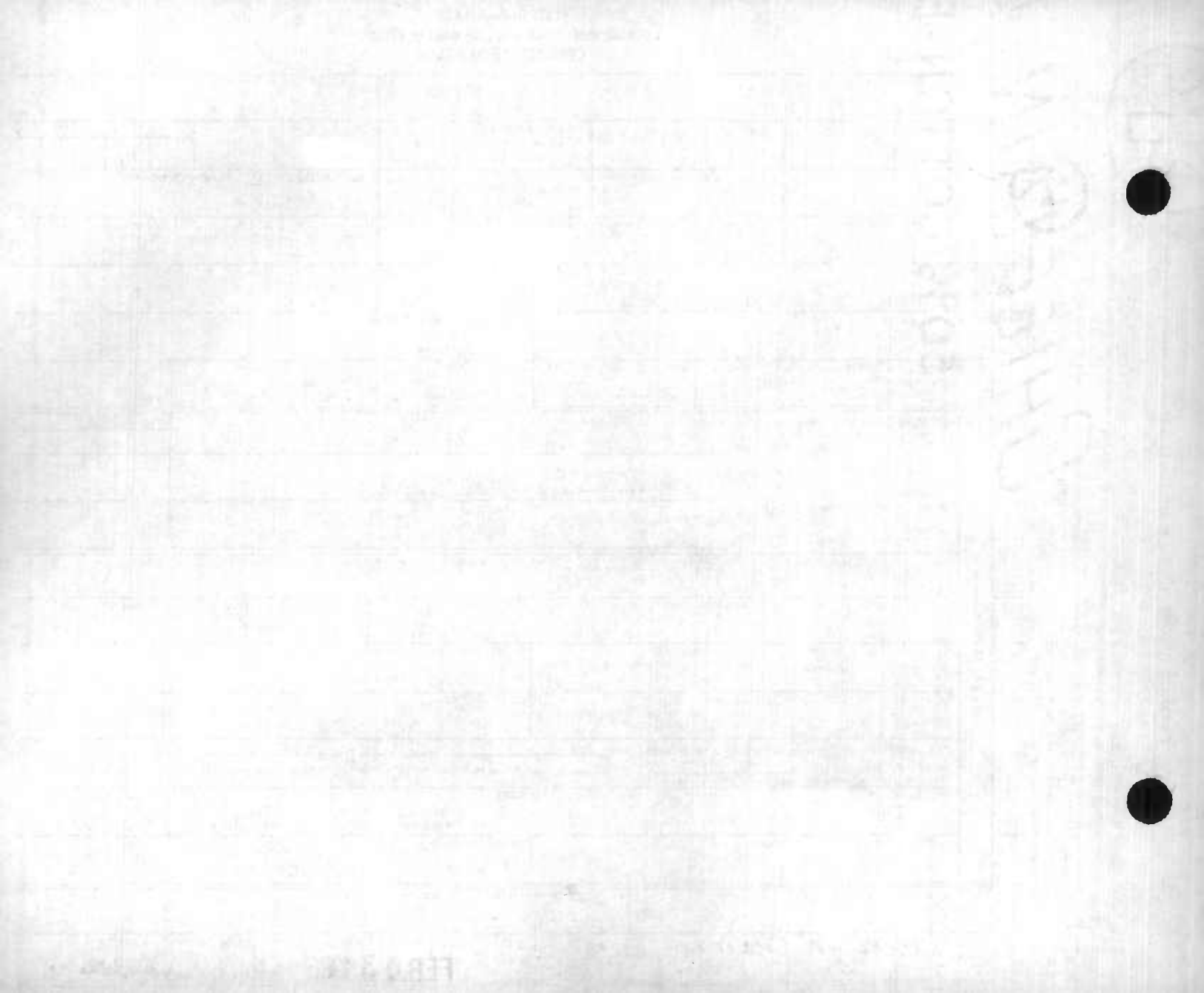
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|---|---|--|--|--|---|----------------------|---|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
B. G. Staci Lauryn Riggs | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 3 85 | | 2b. HOUR
11 54 AM | | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
1 18 85 | | 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
16 | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
West Virginia | | 16b. COUNTY
Berkeley | | 16c. CITY OR TOWN
Hedgesville | | 16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16e. STREET ADDRESS
Rt. 2 | | 16f. ZIP CODE
99999 | |
| 17. FATHER'S NAME FIRST MIDDLE LAST
John Riggs | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Laura Frazier | | | | 19. ADDRESS
John Riggs, Rt. 2, Hedgesville, WV 25427 | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 21. SOCIAL SECURITY NO.
--- | | 22. INFORMANT
John Riggs, Rt. 2, Hedgesville, WV 25427 | | | | 23. ADDRESS | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF -
(b) 2° Perinatal Asphyxia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 25a. DATE OF OPERATION | | | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 25c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 25d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 27a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 27c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 28. I certify that (I) (this hospital) attended the deceased from 1/18, 19 85, to 2/3, 19 85, that (I) (we) last saw the deceased alive on 2/3, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 29a. SIGNATURE
Kottapalli | | | | 29b. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 29c. DATE SIGNED
2/3/85 | | | |
| 30a. PHYSICIAN'S NAME (TYPE OR PRINT)
KOTTAPALLI, M.D. | | | | 30b. ADDRESS
Francis Scott Key Medical Center
4940 Eastern Ave., Baltimore, Md. | | | | | | | |
| 31a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 31b. DATE
2/6/85 | | 31c. NAME OF CEMETERY OR CREMATORY
Tomahawk Cemetery | | 31d. LOCATION CITY OR TOWN COUNTY STATE
Hedgesville Berkeley WV | | | |
| 32. FUNERAL DIRECTOR
Charles M. Brown | | | | 33. ADDRESS
327 W. King St.
Brown Fun. Home POBox 821, Martinsburg, WV 25455 | | | | 34. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 35. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

999999



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 4 0

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BRIDGET T. RIORDAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 20, 1985 | | | 2b. HOUR
M
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 20, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2804 Kildare Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Martin Brennan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Groark | | 13e. STREET ADDRESS / ZIP CODE
2804 Kildare Drive 21234 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
217-54-9822 | | 17. INFORMANT
ADDRESS
Peggy Ferg 2804 Kildare Dr. 21234 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Cardiac Arrest**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6 19 83 , to present 19 84 , that (I) (we) last saw the deceased alive on 7/17 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thal | | DEGREE
D | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James C. Ricely, M.D. | | 22e. ADDRESS
6701 N. Charles Street | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
William Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

January 20, 1950

MEMORANDUM

TO: Mr. Tolson

FROM: Mr. [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 4 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|---|--|-------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNE RIVLIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 23 85 | | 2b. HOUR
722 ^{PM} |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
03 / 12 / 01 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
- - - - | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balt City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hosp of Baltimore | | 12a. USUAL OCCUPATION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
EXECUTIVE | 12b. KIND OF BUSINESS OR
INDUSTRY (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WOOLEN CLIPPING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7311 Park Hgts Ave | 21208 APT #207 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ELIAS RIVLIN | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FANNIE ABRAMOWITZ | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | |
| 16b. SOCIAL SECURITY NO.
111-05-1214 | | 17. INFORMANT
MISS CHARLOTTE RIVLIN 7311 PARK HILLS AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
Anemia, Preleukemia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 2/18, 19 85, to 2/23, 19 85, that (I) (we) lost
saw the deceased alive on 2/23/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Robert E Perry, MD | | DEGREE
MD | | 22c. DATE SIGNED
2/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
Sinai Hosp of Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
BNAI JACOB CEM | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | 23e. DATE REC'D BY REGISTRAR
FEB 27 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25. REGISTRAR'S SIGNATURE
Sol Levinson | | | |

69
42
35
300
1

MEDICAL CERTIFICATION

N12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

3

80% COTTON

WHITE MAX



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like 'white', 'cotton', and 'LW' are visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|--|--|---------------------------------|--|--|----------------|---------------------|--|--|--|----------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | | | | | |
| BERNARD W. ROBINSON | | | | | | 2. DATE ESTIMATED | | | 2 7 19 85 | | | M | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | |
| male | | Black | | 6 13 45 | | 39 YRS. | | MONTHS DAYS | | HOURS MIN | | 2 7 19 85 | | 10P M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | Md. State Penitentiary-954 Forrest St. | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13c. INSIDE CITY LIMITS? | | | | 13d. STREET ADDRESS | | | | | | | |
| Maryland | | | | St. Mary's Waldorf | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | P.O. Box 674 20601 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | | | | |
| John M. Robinson | | | | Catherine Johnson | | | | NO | | | | | | | | | | | |
| 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | |
| Charles Robinson 715 St. Davids Ave | | | | PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple stab wounds</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | 20. AUTOPSY? | | | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | | | | |
| | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | |
| | | | | Subject stabbed. | | | | 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | |
| | | | | 21f. LOCATION | | | | 21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21h. LOCATION | | | | | | | |
| | | | | 954 Forrest St., Balto. | | | | 21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21h. LOCATION | | | | | | | |
| | | | | Md. | | | | 21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21h. LOCATION | | | | | | | |
| | | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| BURIAL | | | | 2/14/85 | | | | Mount Zion Cemetery | | | | Lansdowne, COUNTY Md. STATE | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | 25c. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm C March F/H Inc. 1101 E North Avenue | | | | FEB 13 1985 | | | | John Davidson-Randall | | | | John Davidson-Randall | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, 2, and 3, and place them in the envelope provided. This envelope should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed in the funeral director's office within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504743

| | | | |
|--|--|---|--|
| FOR
1. STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN M ROBINSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 5, 1985 | |
| 3. SEX
F | | 2b. HOUR
10:20PM | |
| 4. RACE
B | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
8 9 21 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sec. Sec. Adm. | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. CITY OR TOWN
B | |
| 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1225 N. Ellwood Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN Morse | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellis Fitts | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-14-2473 | |
| 17. INFORMANT
NAME ADDRESS
Toni Robinson 1225 Ellwood | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Cancer
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk
8 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Large Bowel Obstruction; Intraabdominal Abscess. | | | |
| 19a. DATE OF OPERATION
11/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bowel Obstruction | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19 1985 to 2/5 1985, that (I) (we) last saw the deceased alive on 2/5 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE
W. Cooper | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Cooper | | 22e. ADDRESS
Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-9-85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arbutus | | 23d. LOCATION
Baltimore County Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Jas. A. Morton Sons 1701 Levens | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

RECEIVED
JUN 12 1942
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 4 4

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MIRGINIA M. ROBINSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-12-2-12-85 | | 2b. HOUR 8:35AM |
| 3. SEX
Fe-Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR 2-27-07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pimlico Manor | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Bennie MIDDLE LAST Baker | | | 15. MOTHER'S MAIDEN NAME
FIRST Cora MIDDLE LAST Snowden | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
219-16-8296 | | 17. INFORMANT ADDRESS
Bernice Dates 4402PLAINfield Avenue Apt. 8 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INFLUENZA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 30 January 19 85 to 12 February 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 February 19 85 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE
 | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/12/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR H. VERNON MD | | 22e. ADDRESS
3610 Fuchs Lane 21245 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/16/85 | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Cemetery Anne Arundel Co. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Md. |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | ADDRESS
1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | 25b. REGISTRAR'S SIGNATURE
 |

BP

RECEIVED BY MAIL

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

11/14/71

11/14/71

11/14/71

11/14/71

11/14/71

11/14/71



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Samuel

Rodgers

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 2 8 19 85 2b. HOUR M

3. SEX 4. RACE

Male Black

5. DATE OF BIRTH

3 12 49 35

6. AGE (IN YEARS)

35 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN

2c. DATE PRONOUNCED DEAD

2 8 19 85

2d. HOUR M

11:16 p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto. Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1309 N. Ettings Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE 13b. COUNTY 13c. CITY OR TOWN

Md. Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1309 N. Etting St.

14. FATHER'S NAME

James

MIDDLE

E

LAST

Rodgers

MOTHER'S MAIDEN NAME

Blanche

MIDDLE

Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN) Yes

16b. SOCIAL SECURITY NO.

812-48-0355

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Seizure disorder

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from ☒ Natural causes ☐ accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

Acting Chief

MEDICAL EXAMINER

DATE SIGNED 2/9/85

EXAMINER'S NAME (TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS

111 Penn St.

Balto., MD.

23a. BURIAL, CREMATION, REMOVAL

(TYPE OR PRINT)

23b. DATE

2/12/85

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

23d. LOCATION

CITY OR TOWN COUNTY STATE

Baltimore City MD

24. FUNERAL DIRECTOR

NAME

24a. ADDRESS

112 W. North Ave

25a. DATE REC'D. BY REGISTRAR

1985

25b. REGISTRAR'S SIGNATURE



DMOCT

MINY-FAHA

1938

1938

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 / 4 6

File # G603 item 14, 15
1 - STATE REGISTRAR 5/22/85 rja

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Louise Frances Roemer</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>February 19, 1985</i> | | 2b. HOUR
P M
<i>6:30 P</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>March 24, 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>90</i> | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>S. Baltimore General Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Domestic</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Anne Arundel</i> | | |
| 13c. CITY OR TOWN
<i>Baltimore</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Louis Schenkel</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
<i>Ellen Crampton</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>213-74-4171</i> | | 17. INFORMANT
ADDRESS
<i>Ms. June Roemer Same as #13</i> | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(b)

ASCLO - CDF

DUE TO, OR AS A CONSEQUENCE OF

(c)

*AT EXP. IN FL SSGH*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1980</i> , 19____, to <i>2/10/85</i> , 19____, that (I) (we) last
saw the deceased alive on <i>2/11/85</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) certify that <i>viewed the body</i> after death. | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | DEGREE
<i>MD</i> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>E. ALLOS N. PATAPASCUS</i> | 22e. ADDRESS
<i>803 E. PATAPASCUS AVE BALTIMORE 21225</i> | | |

| | | | |
|---|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>2/23/1985</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Anne Arundel, Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>McGully Funeral Homes</i> | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<i>FEB 25 1985 [Signature]</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

1.

2. 4. 1948

FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
AKA Jack John E. Rogers, JR. | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 4 1985 | | 2b. HOUR
M
AM |
| 1. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 10 28 | 6. AGE (IN YEARS)
LAST BIRTHDAY
56 YRS. | IF UNDER 1 YR.
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Maryland |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John E Rogers, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Loretta Callahan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
WW II 220-20-4948 | | 17. INFORMANT
ADDRESS
June H. Smith 347 Marydell Rd. 21229 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2/5/85 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St. Balto. MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/7/85 | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Maryland |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 |
| 25b. REGISTRAR'S SIGNATURE
Dennis F. Smyth | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Q33014 NOTED X02

Q33014 NOTED X02

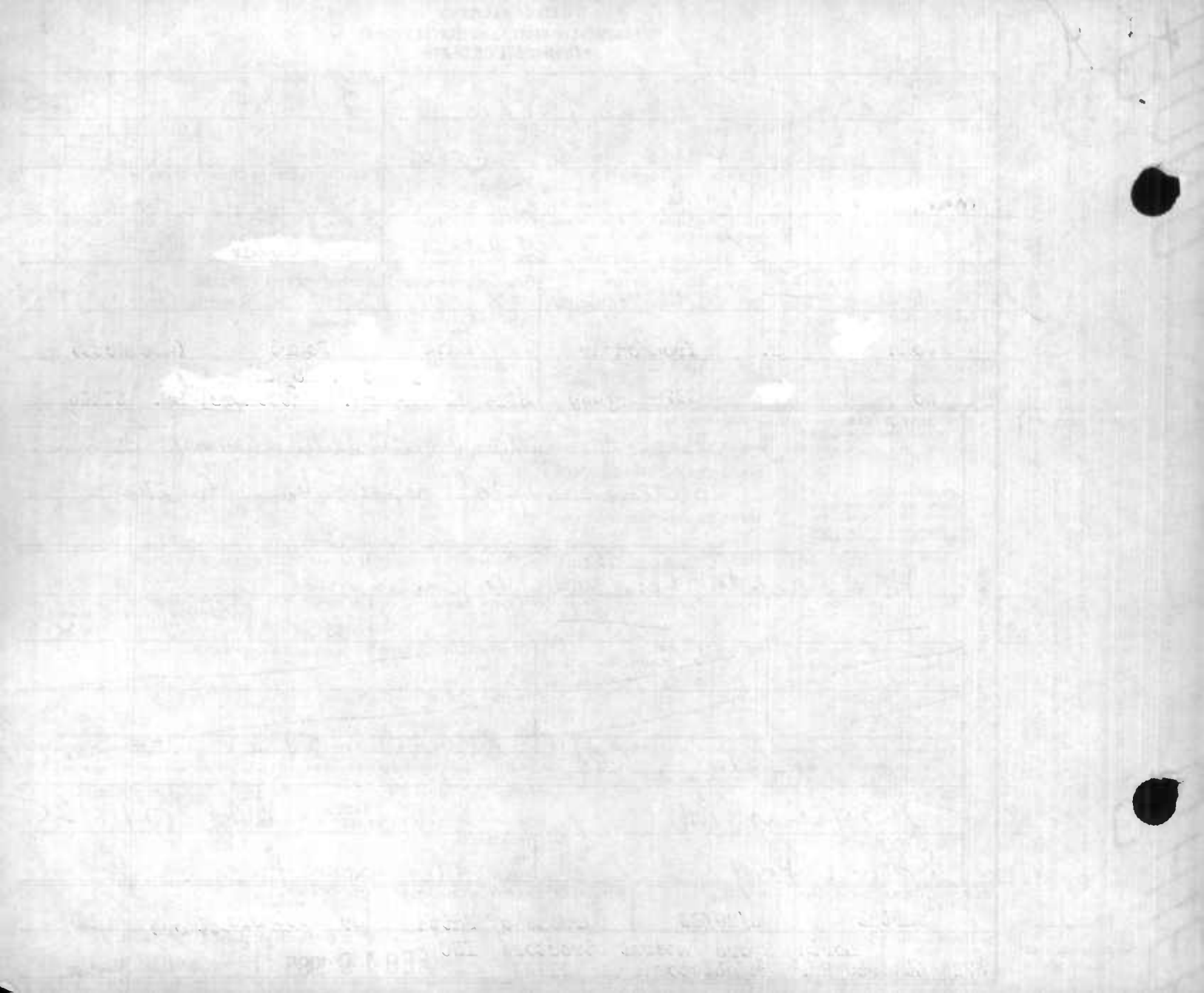


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

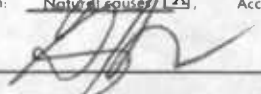

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Evelyn</u> | | | | | 2a. DATE OF DEATH MONTH <u>7</u> DAY <u>16</u> YEAR <u>85</u> | | | | | 2b. HOUR <u>732</u> ⁽⁹⁾ |
| 3. SEX <u>F</u> | | 4. RACE <u>Cauc</u> | | 5. DATE OF BIRTH MONTH <u>8</u> DAY <u>25</u> YEAR <u>16</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS. | | IF UNDER 1 YEAR MONTHS <u>—</u> DAYS <u>—</u> | | IF UNDER 24 HRS. HOURS <u>—</u> MIN. <u>—</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore City</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital of Balow</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Home maker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>5316 Winner Ave 21215</u> | | | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>cc</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | | | | | |
| 14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>T.</u> LAST <u>Ironmonger</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Edna</u> MIDDLE <u>Pearl</u> LAST <u>(nee Wett)</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR (S)) <u>No</u> | | | | | 16b. SOCIAL SECURITY NO <u>217-48-7523</u> | | 17. INFORMANT ADDRESS <u>Albert H. Ropka</u>
<u>5316 Winner Ave., Baltimore, MD. 21215</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Suspect Ruptured ventriculomaneyss</u>
DUE TO, OR AS A CONSEQUENCE OF
b) <u>Antero-septal myocardial infarctin</u>
DUE TO, OR AS A CONSEQUENCE OF
c) <u>—</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HTN, acute Left lowerlobe pneumonia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>—</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u> | | 21f. LOCATION STREET <u>—</u> | | CITY OR TOWN <u>—</u> | | COUNTY <u>—</u> STATE <u>—</u> | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>85</u> , to <u>2/16</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>RE Perry MD</u> | | | | | DEGREE <u>—</u> | | | 22c. DATE SIGNED <u>2/16/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert E. Perry</u> | | | | | 22e. ADDRESS <u>3624 Patterson Ave</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>2/20/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u> | | 23d. LOCATION CITY OR TOWN <u>Overlea</u> COUNTY <u>Baltimore</u> STATE <u>MD</u> | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Loring Byers Funeral Directors, INC</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>FEB 19 1985</u> | | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u> | | | |
| 8728 Liberty Rd. Randallstown, MD 21133 | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|----------------------|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Cecilia Roscoe
(Cecelia) (Roscoe) A. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2 19 85 | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH
MONTH DAY YEAR 7 13 15 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 69 YRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | 2b. HOUR 7:31 | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1115 N. Calhoun Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS 1115 N. Calhoun St. 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST John F. Turner | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Eva Cooper | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 214-40-7820 | | 17. INFORMANT ADDRESS Reuben C. Roscoe 1115 N. Calhoun St | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 2/20/85 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | ADDRESS 111 Penn St. | | | | | Balto, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE  | | | | |

30% COTTON BLEND

ONE HALF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 5 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ODELL ROSEBOROUGH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 5 85 | | 2b. HOUR
4:40p M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
11 3 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven Veteran Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Marshall Roseborough | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Mobley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
249-44-9094 | | 17. INFORMANT ADDRESS
Annie Roseborough 2604 Allendale Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> 2 wks
DUE TO, OR AS A CONSEQUENCE OF (c) <u>wide spread oat cell cancer of lung</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11d | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 29</u> , 19 <u>85</u> , to <u>FEBRUARY 5</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>FEBRUARY 5</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>R. Bernier MD</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/6/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>R. Bernier M.D.</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/9/85 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | ADDRESS
1101 E North Avenue | | 25a. DATE REC'D BY REGISTRAR
FEB 8 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 5 1

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANK ROSENFELD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 27, 1985 | | | 2b. HOUR
11:19 PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEBRUARY 1, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
843 W. 36th ST. 2nd FLR 21211 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ATTENDANT | | 12b. KIND OF BUSINESS OR INDUSTRY
PARKING LOT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
843 W. 36th ST. 2nd FLR. 21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CANTOR DAVID ROSENFELD | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE SCHREIBER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWII-ARMY | | | | 16b. SOCIAL SECURITY NO.
218-14-3826 | | 17. INFORMANT
ADDRESS
APT. 711 (21210) MITCHELL ROSENFELD 1190 W. NORTHERN PKWY | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Ac - MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) HAS CVB
DUE TO, OR AS A CONSEQUENCE OF
(c) ± 30 yrs -
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 75 to 2/27 , 19 85 , that (I) lost saw the deceased alive on 11/19 , 19 84 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | | | |
| 23a. SIGNATURE
DR. RAYMOND CAPLAN | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
3/27/85 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 23c. ADDRESS
2435 W. BELVEDERE AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
3/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | | | | | 25a. DATE RECD. BY REGISTRAR
MAR 7 1985 | | 25b. REGISTRAR'S SIGNATURE
Juba Davidson-Rendell | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



WHITE
COTTON
DOWN

1/2
1/2



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 5 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RAY STERN ROSENTHAL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 13, 1985 | | | 2b. HOUR
12 25 P M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 9, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6314 GREENSPRING AVE. APT. 101 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6314 GREENSPRING AVE. #101 (21209) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SIGMUND STERN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTHA FULD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
212-40-5531 | | 17. INFORMANT
ADDRESS
WILLIAM J. ROSENTHAL 8207 CRANWOOD CT. 21208 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c.
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MI</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCVD</u>
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>hours</u>
<u>years</u> | | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>2/13</u> , 19 <u>85</u> , to <u>2/13</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>2/13/85</u> , 19 <u>85</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Louis W. Miller MD</u> DEGREE | | | | | | 22c. DATE SIGNED
2/13/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOUIS MILLER | | |
| 22e. ADDRESS
6804 PARK HEIGHTS AVE. BALTO., MD. (21215) | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/15/85 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Jane Harrison-Randall</u> | | |

BOX COTTON FIBER



CHIL-AM

Box 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
Vernon Russell Rowzee | | | | 2a. DATE OF DEATH
2/19/85 | |
| 3. SEX
Male | | | | 7b. HOUR
1223 P | |
| 4. RACE
White | | 5. DATE OF BIRTH
April 27, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bus Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Mass Transit | | 13a. STATE
Md. | |
| 13b. COUNTY
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
4901 Wetheredsville Road 21207 | | 14. FATHER'S NAME
First: Clyde Middle: E. Last: Rowzee | |
| 15. MOTHER'S MAIDEN NAME
First: Emily Middle: A. Last: Bowersox | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes WW II | | 16b. SOCIAL SECURITY NO.
216-20-3704 | |
| 17. INFORMANT
5901 Cecil Ave. - Balto., Md.
Miss Catherine L. Rubin - 21207. | | 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Beverly J. Kelsey MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/19/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Beverly J. Kelsey | | 22e. ADDRESS
225 Greene St | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. - Garrison Forest - Maryland | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills | | 24. FUNERAL DIRECTOR
Sterling Funeral Estate, P.A.
736 Edmondson Ave. Catonsville, Md. 21228 | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Beverly J. Kelsey | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 13 85 | | | | | | | 2b. HOUR 6:40 A.M. | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LARRY RUCKER | | | | | 3. SEX male | | | | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 19 56 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS | | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | | | | 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE 314 Allendale St. 21229 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Floyd Johnson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Rucker | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 214-68-3328 | | | | | 17. INFORMANT ADDRESS Anna Rucker 314 Allendale Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL BRONCHOPNEUMONIA, ACUTE
DUE TO, OR AS A CONSEQUENCE OF (c) ACQUIRED IMMUNODEFICIENCY SYNDROME | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DAYS | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c | | | | | | | | | | MONTHS | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/4/85, 19 85, to 2/13, 19 85, that (I) (we) last saw the deceased alive on 2/13, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE DEGREE Steven H. Pearlman M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 2/13/85 | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN H. PEARLMAN | | | | | 22e. ADDRESS ST. AGNES HOSPITAL 500 S. CATON AVE | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | | 23b. DATE 2/16/85 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 k North Avenue | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 15 1985 | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |

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UNIT 1101103

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UNIT 1101103



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| DECEASED NAME
(TYPE OR PRINT)
WILLIAM B. RUSH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 85 | | 2b. HOUR
10:40p.m. |
| 1. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
3/31/20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC 3900 LOCH RAVEN BLVD 21218 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY
STEEL | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
ESSEX | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
302 OBERLE AVE. 21221 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM RUSH | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
THERESA TREM GA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 218039928 | | 17. INFORMANT
ADDRESS
VAMC 3900 LOCH RAVEN BLVD 21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Presumed Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(c) Undiagnosed Abdominal pain | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Undiagnosed Abdominal pain | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 15, 19 85 to FEBRUARY 16, 19 85 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive <input checked="" type="checkbox"/> FEBRUARY 16, 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. Clemens MD | | DEGREE
MD | | 22c. DATE SIGNED
2/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Clemens MD | | 22e. ADDRESS
3900 LOCH RAVEN BLVD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELL | | ADDRESS
300 MACE | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | |
|--|--|----------------|----------------|---|--|---|--|--|------------------|--|--|--|--|------------------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Edgar | | | MIDDLE
C. | | | LAST
Russ JR. | | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2-6 19 85 | | 26. HOUR
M | | | | | |
| 3. SEX
Male | | 4. RACE
Coe | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 27 19 14 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
70 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 21. DATE PRONOUNCED DEAD
2-7 19 85 | | 24. HOUR
8:55 a. M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
83 Va | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11 W. 20th St., 10T | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
11 W. 20th St. Apt 10T 21218 | | | |
| 14. FATHER'S NAME
Edgar C | | | | 15. MOTHER'S MAIDEN NAME
Ellen Russ | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
1 WWT 220-03-21374 | | | | 17. INFORMANT
Mrs Patricia Russ 1815 N. Payson St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
2-8-85 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2-13-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | | | 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Co. | | STATE
Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |

80% COTTON FIBER

MADE IN U.S.A.

WATKINS



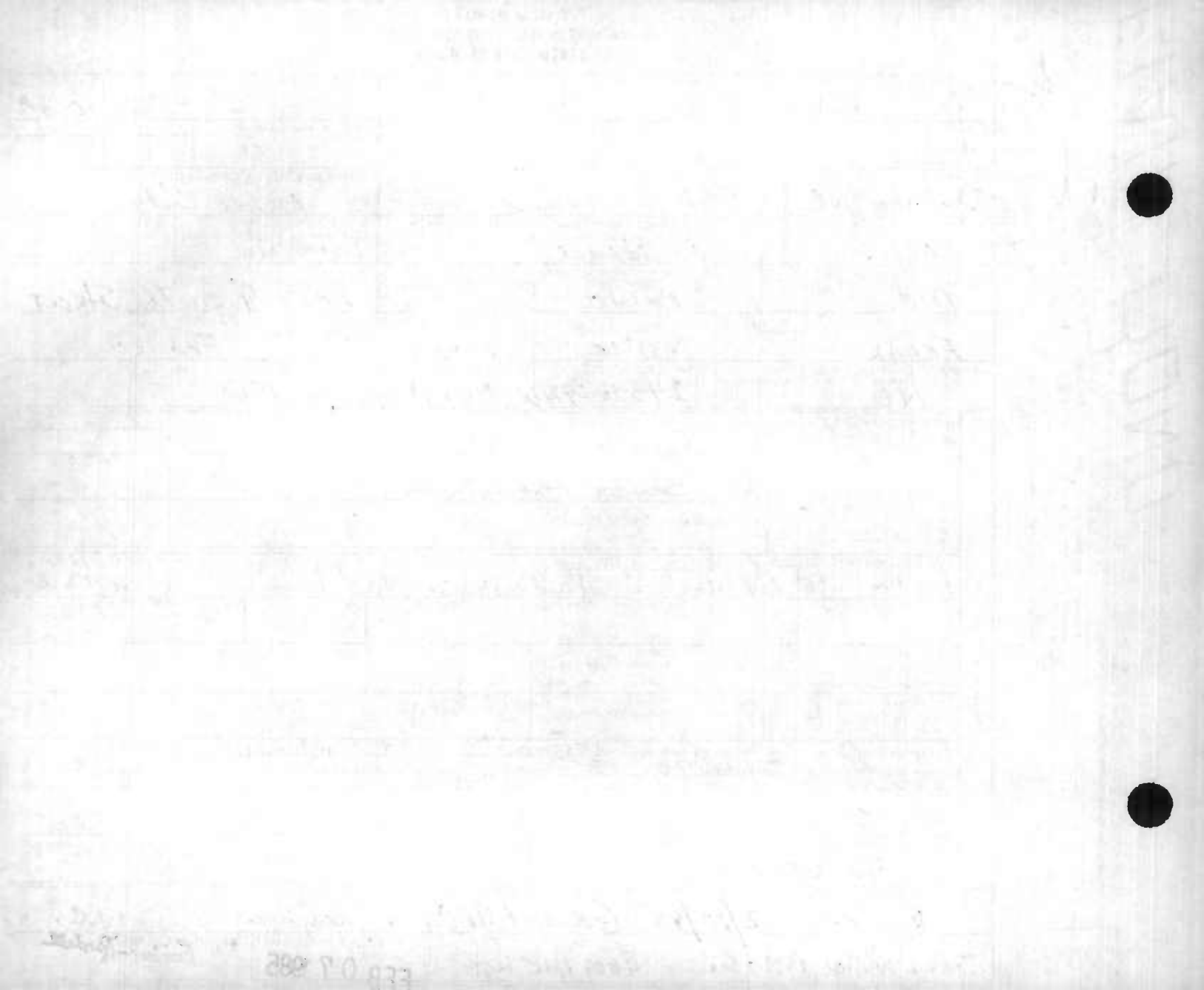
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen B. Russell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 4 85 | | | 2b. HOUR
10:30 AM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 7 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Cash Corner, NC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Residence | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
21204 1817 Aisquith Street | | 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY Frances | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
243-18-0474 | | 17. INFORMANT
MARY Phillips | | ADDRESS
1817 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF:
(b) Severe Atherosclerosis | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF:
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Atrial Fibrillation | | | | | | | |
| Poor Healing of Amputation leg wound and Gastrostomy wound / Pulmonary Atelectasis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 31, 19 84 to February 4, 19 85 , that (I) (we) last saw the deceased alive on January 28, 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
F. Wiegmann | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. WIEGMANN | | 22e. ADDRESS
8406 Hartford Rd. / Baltimore, Md. 21234 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/10/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenhill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bayboro N.C. | |
| 24. FUNERAL DIRECTOR
NAME
Jeff Miller F.H. Service | | | | ADDRESS
4609 Park Hgts | | 25a. DATE REC'D. BY REGISTRAR
FEB 07 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Paula R. Riddell | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

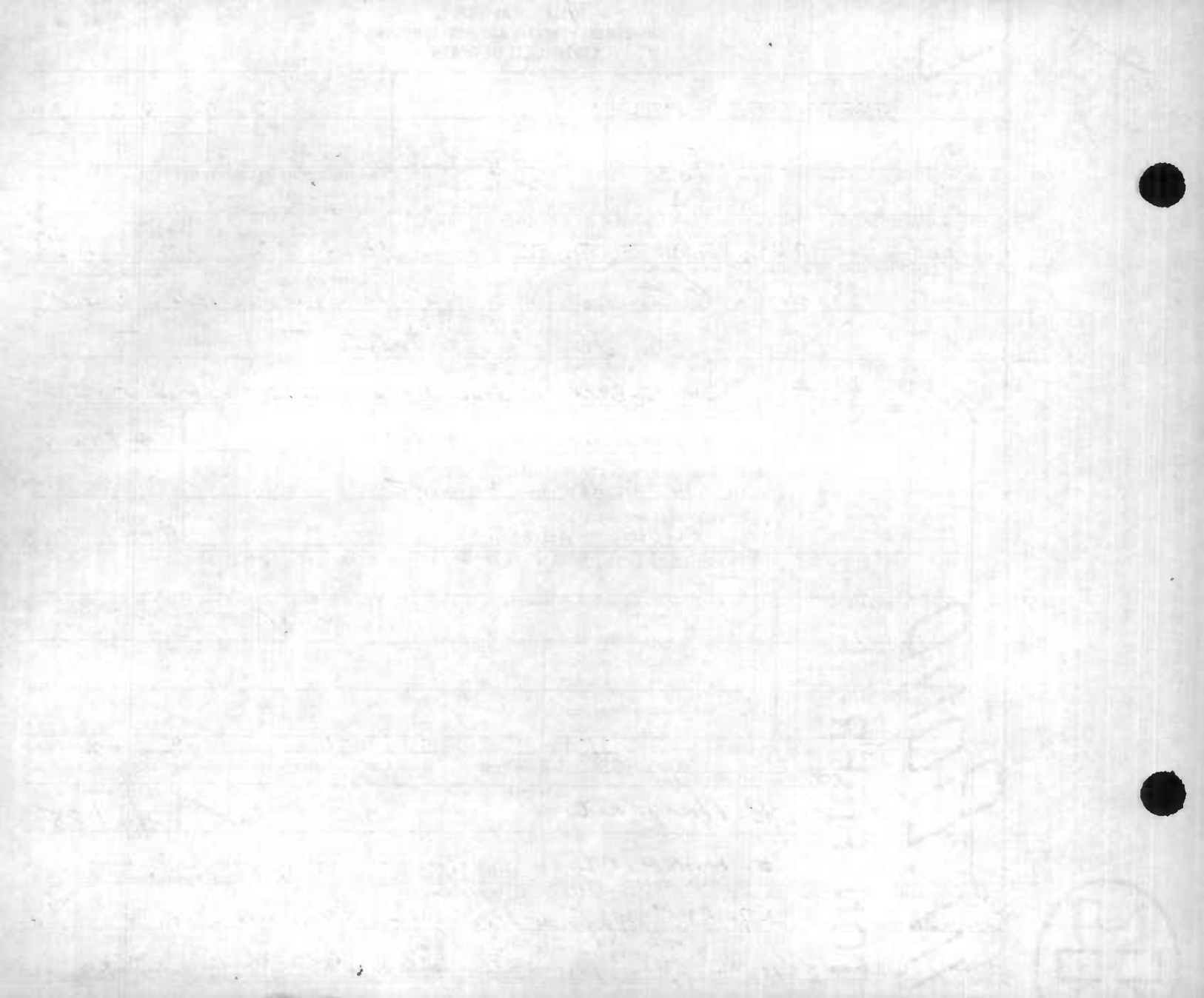
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 1B above any injury, or other traumatic event, the medical examiner must be called at once.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2b. HOUR | | | |
| KENNETH LEE RUSSELL | | | | 2 6 85 1:20 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | 5-29-1936 | | 48 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Ind. | | U.S.A. | | | | BALTIMORE, CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | VAMC, BALTIMORE, MD. 21218 | | Stock Clerk | | Grocery Store | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Ind. | | Balt. Co. | | Catonville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 14 Sanford Ave. 21228 | | | |
| ? | | Russell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes | | Vietnam | | Tadine J. Russell 1203 Jones St. 21223 | | | |
| | | 219-32-6988 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | 47 hours |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HEPATO RENAL FAILURE</u> | | | | | | | 1/14/85 - 2/6/85 |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ALCOHOL ABUSE</u> | | | | | | | MANY YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that <u>XXX</u> (this hospital) attended the deceased from <u>1/14</u> , 19 <u>85</u> , to <u>2/6</u> , 19 <u>85</u> , that <u>X</u> (we) last saw the deceased alive on <u>2/6</u> , 19 <u>85</u> , and that <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) <u>XXX</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Joyce B. Harp MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 2/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| JOYCE B. HARP MD | | | | 3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Cremation | | 2-7-1985 | | Westview Mem. Park | | Catonville Balt. Co. Ind. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| John J. Cowan & Son Inc. 901 N. Calver St. Balto. Md. 21223 | | | | FEB 1 5 1986 Julia Davidson-Randall | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR John H. Rust | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN H RUST | | | | 2b. DATE OF DEATH MONTH DAY YEAR 2 26 85 | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9 18 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTH PLACE (STATE OR FOREIGN) VIRGINIA | | 7c. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE SCHOOL TRAUMA | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ? | | 12b. KIND OF BUSINESS OR INDUSTRY ? | |
| 13a. STATE MD | | 13b. CITY OR TOWN BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE 1700 S. PAUL ST. 21202 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) ? | | 16b. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Lenora Black 1709 St. Paul St. 21202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTRACRANIAL Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) FALL ON CURB
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) ?
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARDS, RENAL FAILURE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 9 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) fell at home | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AT HOME | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1700 S. PAUL ST. BALTIMORE MD. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 26 1985 to 26 19 85 , that (I) (we) last saw the deceased alive on 26 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE CERTIFICATION APPROVED BY MEDICAL EXAMINER
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 2/26/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC L. Bloomfield | | 22e. ADDRESS 22 S. GREEN ST. BALTIMORE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 3-1-85 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville MD. | |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA ADDRESS 1300 Eutaw Place | | | | 25a. DATE REC'D. BY REGISTRAR MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP



ALPHABETICALLY

ALPHABETICALLY

RECEIVED

MAY 1 1968

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5 0 4 7 6 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) THOMAS RYAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 16 / 85 | | 2b. HOUR
4³⁰ PM |
| 3 SEX
Male | 4 RACE
Caucasian | 5 DATE OF BIRTH
MONTH DAY YEAR
3 16 1936 | | 6 AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheetmetal | 12b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James Ryan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Mc Closkey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR PARTIAL) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
579-09-2180 | | 17. INFORMANT
ADDRESS
Jacqueline Little 6116 Belair Road | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arteriosclerotic Cardiovascular Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **Acute Influenza; Osteoporosis; Dementia.**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (we) (they) attended the deceased from **12/28/84** to **2/16/85**, that (I) (we) (they) last saw the deceased alive on **1/22/85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.

22b. SIGNATURE

DEGREE

MDATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

2/16/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ALBERT B. BRADLEY, M.D.**4900 BELAIR RD. BALTO., MD. 21206**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)**Removal**

23b. DATE

2/16/85

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME**Anatomy Board**

ADDRESS

Balto., Md.

25. DATE RECD. BY REGISTRAR

26. REGISTRAR'S SIGNATURE

FEB 25 1985**J. Davidson-Randall**

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

2/18/47

RYAN

THURSDAY

Dear Mr. Ryan,
I have just received your letter of the 14th inst. and am glad to hear from you. I am well and hope this finds you the same.

I am sorry that I cannot do more for you at present, but I am sure that you will understand my position. I will do what I can for you when I am able to do so.

Very truly,
Your friend,
[Signature]

I am sure that you will understand my position. I will do what I can for you when I am able to do so.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04762

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CLARA SACHS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 85 | | | 2b. HOUR
8:05pm | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 26 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
US | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BAL. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
- | |
| 12b. KIND OF BUSINESS OR INDUSTRY
- | | 13a. STREET ADDRESS
2208 1/2 Sulgrave Ave | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
2208 1/2 Sulgrave Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATHAN WAGNER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FANNIE UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
220-46-4057 | |
| 17. INFORMANT
ADDRESS
Jacqueline SACHS 205 E. Joppa Rd - Towson, MD | | 18. DATE OF DEATH
2-16-85 | | 19. TIME OF DEATH
8:05pm | | 20. PLACE OF DEATH
SINAI HOSP. | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac asphyx.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Ac. MI. pericarditis.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

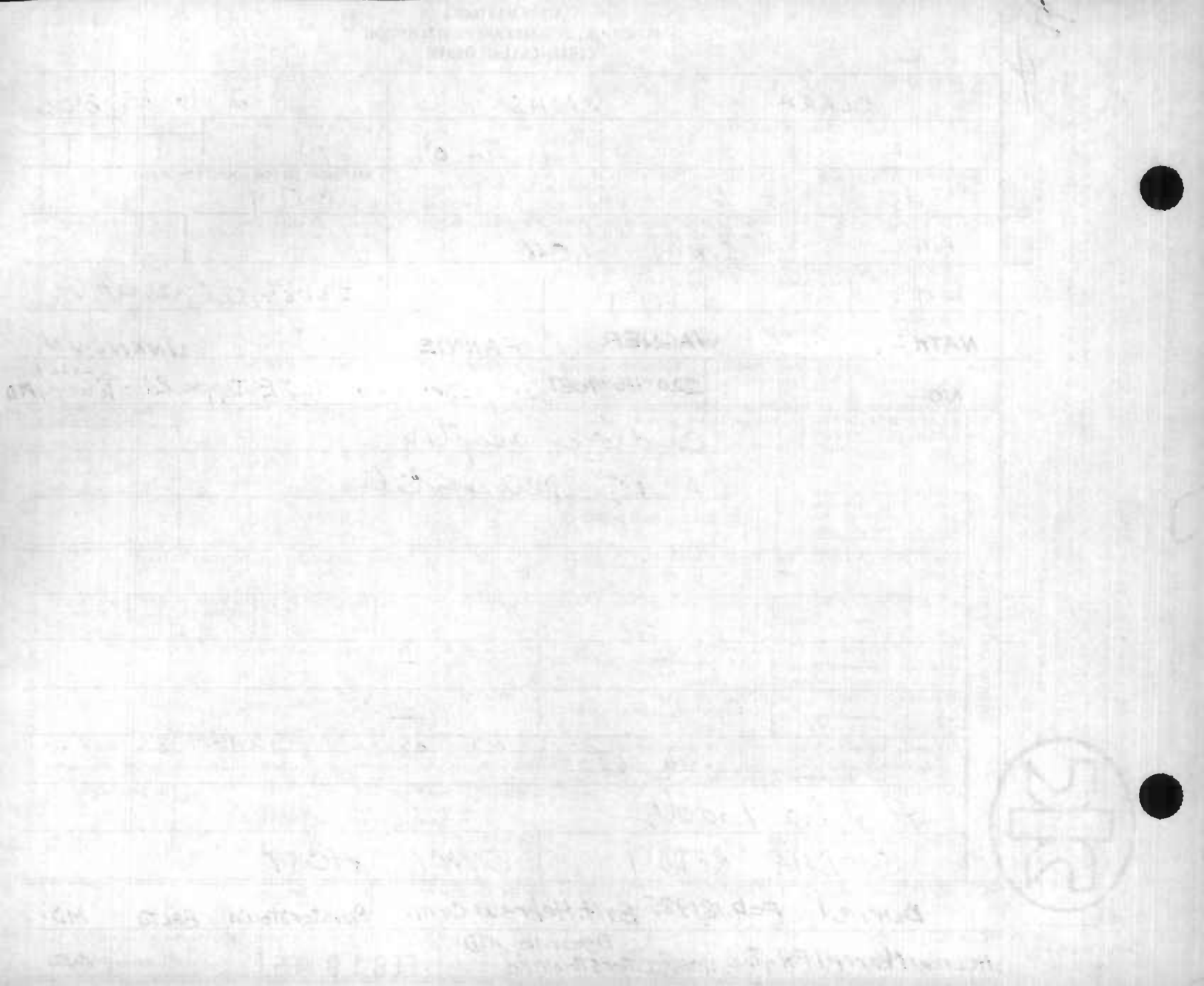
| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
- | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
- | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-7-1985 to 2-16-1985 , that (I) (we) last saw the deceased alive on 2-16-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Shobha Reddy | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHOBHA REDDY | | | | 22e. ADDRESS
SINAI HOSP. | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 18, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Balt. Hebrew Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Reisterstown BALTO MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hebrew Memorial F.H., Inc. 1100 Reisterstown Rd Pikesville, MD | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
William R. Rende | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504763

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANDREW P. SADEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/24/85 | | 2b. HOUR
2:10 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 29, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Sear's | | 12b. KIND OF BUSINESS OR INDUSTRY
Manger |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Sadey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Yule | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
232-01-6301 | | 17. INFORMANT ADDRESS
Mrs. Andrea Van Horn 21128 17 Fox Hill Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory distress
DUE TO, OR AS A CONSEQUENCE OF (b) cerebral/cerebellar infarcts (stroke)
DUE TO, OR AS A CONSEQUENCE OF (c) aspiration / ALL infiltrate | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
hepatic encephalopathy 2° STON; lethargy, PUD | | | | | |
| 19a. DATE OF OPERATION
NA | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NA <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. NA 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
NA | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> NA
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
NA | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
NA | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 85 , to 2/24 19 85 , that (I) (we) last saw the deceased alive on 2/24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jasmine Chen mds | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JASMINE CHEN | | 22e. ADDRESS
UNION MEMORIAL HOSP, BALTO, Md 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
2-25-85 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | ADDRESS
Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | 25b. REGISTRAR'S SIGNATURE
Davidson-Rindell |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

3

8-10-19

10-10-19

DAY

10

10-10-19

CITY

BALTIMORE

UNION MEMORIAL HOSPITAL

BALTIMORE

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10-10-19

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (1))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 5 0 4 7 6 4 | |
|--|--|----------------------|--|---|--|---|--|--|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Derek (Derek) | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH XX DAY 2 YEAR 1985 | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH 5 DAY 8 YEAR 74 | | 6. AGE (IN YEARS LAST BIRTHDAY) 10 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH 2 DAY 27 YEAR 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1606 W. Lafayette Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School | | 12b. KIND OF BUSINESS OR INDUSTRY Student | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1606 W. Lafayette. | | | |
| 14. FATHER'S NAME FIRST BARRY MIDDLE St LAST Thomas | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Glenice MIDDLE LAST Harris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Ida Hudnell | | | | ADDRESS 1227 W. Lafayette | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon monoxide intoxication
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 26 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Inhalation of furnace fumes | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET 1606 W. Lafayette St. CITY OR TOWN Balto. COUNTY City, STATE Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 2/27/85 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | ADDRESS 111 Penn St. | | | BALTO, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | 23b. DATE 3/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hall | | | | 23d. LOCATION CITY OR TOWN Balto COUNTY STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Jeff Miller F.S. ADDRESS 4609 Park Hgts | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

WINDMILL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 signifies injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 4 7 6 5 | | | |
|---|--|--|--|---|--|--|---|
| FOR
1. STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CASIMER J. SAMBORSKI | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 16, 1985 | | 2b. HOUR
9:38AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 11 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY
Local #48 | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Baltimore Dundalk | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3458 McShane Way 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph J. Samborski | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Hanus | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-07-3129 | | 17. INFORMANT
ADDRESS
Lillian A. Samborski Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) lung Ca
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
min.
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12 19 85 to 2/16 19 85 , that (I) (we) lost saw the deceased alive on 2/16 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dimitri Merine | | | | DEGREE
MD | | 22c. DATE SIGNED
2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dimitri Merine | | | | 22e. ADDRESS
600 N. WALKER ST | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/20/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | | | 25a. DATE REC'D BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
G. Davidson-Randall | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|---|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stephanie Rutherford Sameth
STEPHANIE SAMETH | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 17 85 | | 2b. HOUR
9 15 AM | |
| 3 SEX
F | 4 RACE
W | 5 DATE OF BIRTH MONTH DAY YEAR
9 7 38 | | 6 AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balt | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY
Maryland Baltimore | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
641 Pat Kirk 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Philip | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nancy Randolph | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
224483602 | | 17. INFORMANT ADDRESS
Nancy R Porter Alexandria, Virginia 22314 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic Carcinoma c Metastasis
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: upper GI bleeding | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate | | | |
| 19a. DATE OF OPERATION
2/17/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
4:19 PM 2/17/85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
SINAI HOSPITAL Baltimore City MD | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17/85 to 2/17/85 that (I) (we) lost 2/17/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bruce S. Gillies | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE S. GILLIES | | 22e. ADDRESS
SINAI HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Ivy Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR NAME
Demaine Funeral Homes, Inc Alexandria, Virginia | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Harold Sanders | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 8, 1985 | | 2b. HOUR
8:30PM | | | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 1 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
55 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodial | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE
md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13e. STREET ADDRESS / ZIP CODE
3500 Woodbrook 21217 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GENVA SAUNDERS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
249-443695 | | 17. INFORMANT
ADDRESS
FRANCES SCOTT 2320 Braddish | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Gastric Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that xx this hospital attended the deceased from <u>January 31</u> , 19 <u>85</u> , to <u>February 8</u> , 19 <u>85</u> , that ix (we) lost saw the deceased alive on <u>February 8</u> , 19 <u>85</u> , and that in ix (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ix (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i>
DEGREE | | | | | | 22c. DATE SIGNED
2/8/85 | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Galante MD | | | | | | 22f. ADDRESS
C/O Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
MT Zionburia | | | | 23b. DATE
2/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT ZION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. md. | | | |
| 24. FUNERAL DIRECTOR
NAME
William C. Brown | | | | | | 25. DATE RECEIVED BY REGISTRAR
FEB 13 1985 | | | | | |
| ADDRESS
1204 North Ave. | | | | | | REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

7

100



UNIT 1

UNIT 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 6 8

REG. NO.

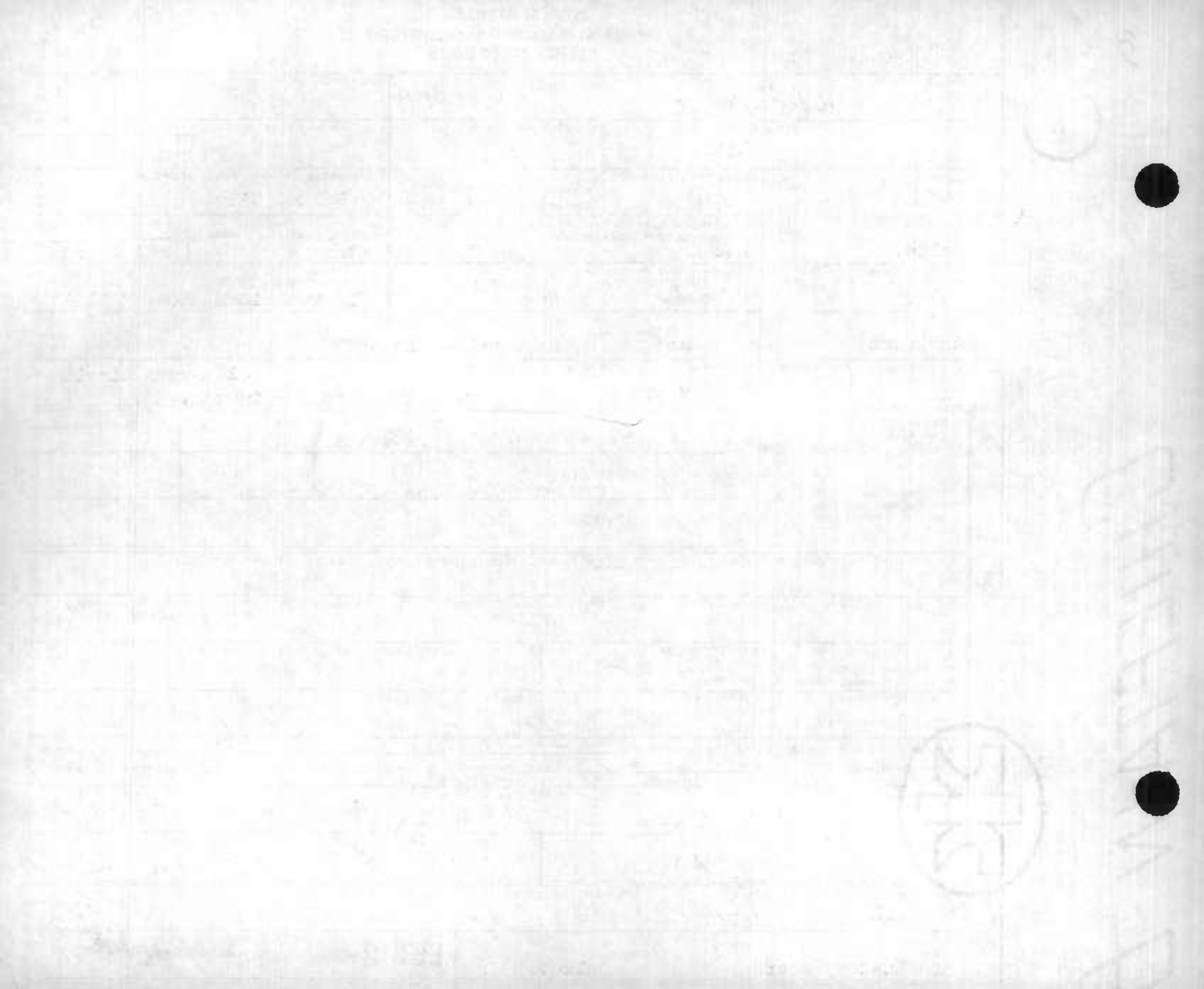
| | | | | | | | |
|--|--|--|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOIS M SANDY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/20/85 | | 2b. HOUR
424 PM | | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-19-17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrical Assembly | | 12b. KIND OF BUSINESS OR INDUSTRY
Glen L. Martin Corp | |
| 13a. STATE
MD | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS, ZIP CODE
1631 Ingelside Ave. Apt. 26 | | 13f. CITY OR TOWN
Baltimore | | 13g. STATE
MD | | 13h. ZIP CODE
21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Martin Luther Rowe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Irene Stonebraker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-05-2316 | |
| 17. INFORMANT
James T. Sandy | | 18. ADDRESS
1807 Cremen Rd. 21122 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
DUE TO, OR AS A CONSEQUENCE OF (b) Valvular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| 19a. DATE OF OPERATION
2/20/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral + Aortic Stenosis | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. DATE OF INJURY
MONTH DAY YEAR
2/20/85 | | 21h. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 , 19 85 , to 2/20 , 19 85 , that (I) (we) lost saw the deceased alive on 2/20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
B A Collins MD | | 22c. DEGREE
MD | | 22d. DATE SIGNED
2/20/85 | | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)
B A Collins MD | | 22g. ADDRESS
U. of Md Hosp. 225 Greene St. Balt. Md. | | 22h. CITY OR TOWN
Baltimore | | 22i. STATE
Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | 24a. ADDRESS
4107 Wilkens Ave. | | 24b. CITY OR TOWN
Baltimore | | 24c. STATE
Md. | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | 25c. CITY OR TOWN
Baltimore | | 25d. STATE
Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR Katherine Sarchett | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Katherine Sarchett</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>2/17/85</i> | | 2b. HOUR <i>M</i> |
| 3. SEX <i>F</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>9/2/11</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA - Pa.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE <i>MD</i> | 13b. CITY OR TOWN <i>Baltimore</i> | 13c. CITY OR TOWN <i>Baltimore</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>524 Tunbridge Rd. 21212</i> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Ethelbert Rose</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Estelle Richard</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>2 577-18-4149</i> | | 17. INFORMANT ADDRESS <i>29 Acorn Circle Mr. Charles Rose - Towson, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>untreated diabetes</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypoglycemia coma</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/17/85</i> , 19 <i>85</i> , to <i>2/17/85</i> , 19 <i>85</i> , that (I) (we) lost <i>saw the deceased alive on 2/17/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Marie Dan</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>2/17/85</i> | |
| 22d. PHYSICIAN'S NAME (USE PRINT) <i>Marie Dan</i> | | 22e. ADDRESS <i>9051 Park 7 Mt Airy Church</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | 23b. DATE <i>2/17/85</i> | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>City</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i> | | ADDRESS <i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 22 1985</i> 25b. REGISTRAR'S SIGNATURE <i>J. A. Davidson</i> 25c. <i>1/093</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

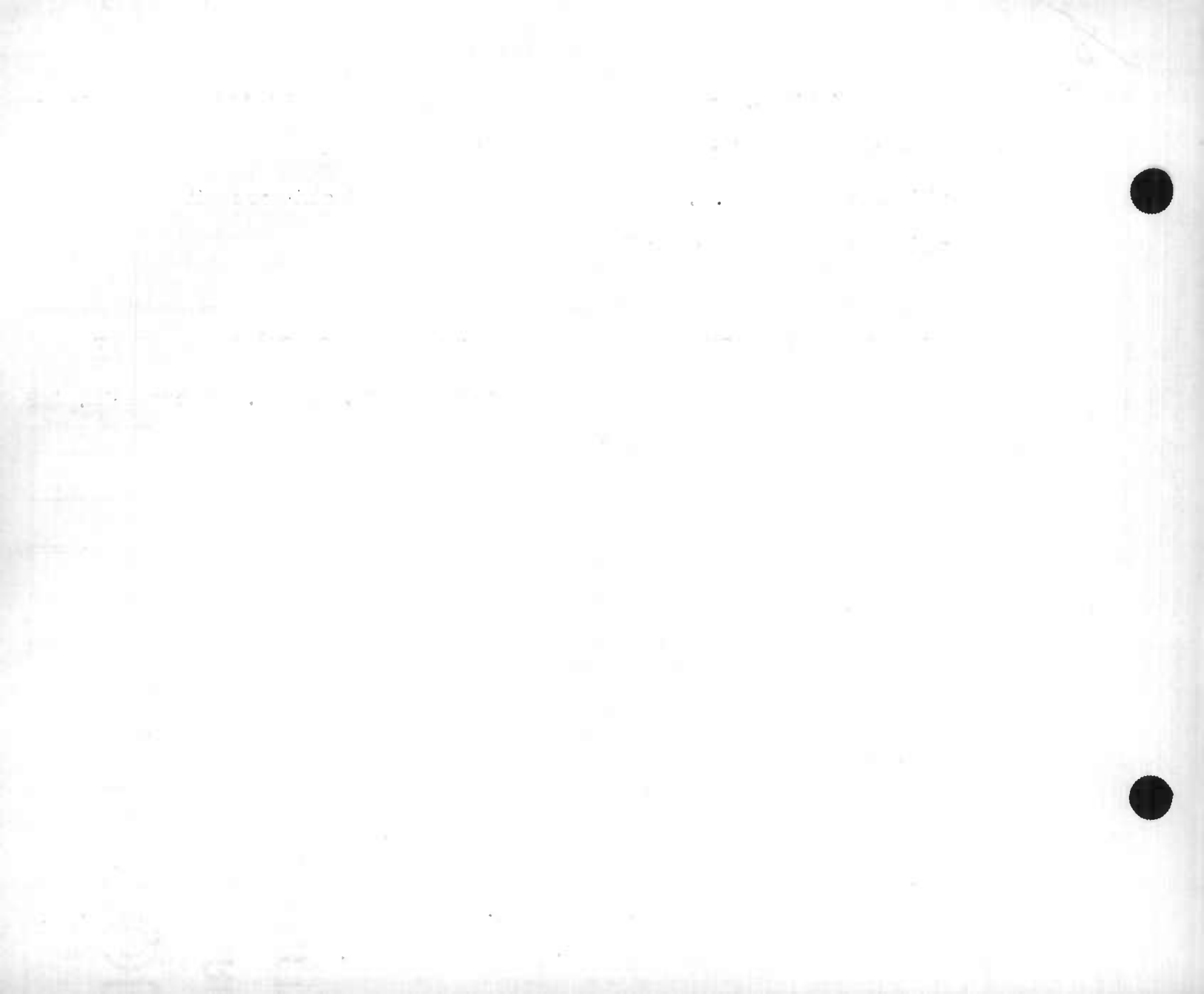
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 7 0

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Minnie L. Sater | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02/11/85 | | | 2b. HOUR
11:25am | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
05-24-99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wesley Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Hostess | | 12b. KIND OF BUSINESS OR INDUSTRY
Funeral Home | |
| 13a. STATE
Maryland | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Albert Warner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Catherine O'Connor | | | 16. STREET ADDRESS
2211 West Rogers Avenue 21209 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
215-34-0821 | | 17. INFORMANT
ADDRESS
Wesley Home, 2211 W. Rogers Ave., #09 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Malnutrition to anorexia, no angina | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 85 , to 2/11 , 19 85 , that (I) (we) lost saw the deceased alive on 2/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
Robert Liberto, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-13-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT LIBERTO | | | 22e. ADDRESS
2211 W. Rogers Ave. 21209 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
02 14 85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sater's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chestnut Ridge, Balto., Co., Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Burge-Henss Funeral Home, Baltimore, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04771

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|----------------------|---|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Pearl | | | 2b. DATE KNOWN OF DEATH
MONTH XX DAY 2-14 YEAR 1985 | | | 7b. HOUR
M 2:58 P. M | | |
| 3. SEX
F. | 4. RACE
W. | 5. DATE OF BIRTH
MONTH 12 DAY 14 YEAR 1914 | 6. AGE (IN YEARS)
LAST BIRTHDAY 70 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH 2-14 DAY 19 YEAR 85 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
704 N. Collington Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Counter Person | | 12b. KIND OF BUSINESS OR INDUSTRY
Cafeteria |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Dreese MIDDLE LAST Moyer | | | 15. MOTHER'S MAIDEN NAME
FIRST Stella MIDDLE LAST Rhoads | | | 16. SOCIAL SECURITY NO.
184-20-5834 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 17. INFORMANT
Terry Sattler | | | ADDRESS
4404 Colman Gardens Dr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
2-15-85 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth | | | ADDRESS
111 Penn Street, Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Entombment | | | 23b. DATE
2-16-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore, COUNTY Md. | |
| 24. FUNERAL DIRECTOR
NAME
John M. Weber & Sons Inc. | | | | | ADDRESS
401 S. Chester St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | |
| | | | | | 25b. REGISTRAR
Lila Davidson-Robles | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 7 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|---|---|--|--|--------------------------------|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Virginia | | | FIRST MIDDLE LAST
Saunders | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-12-85 | | | 2b. HOUR
4:30 M | | | | |
| 3. SEX
F | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 17 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Key Medical Center | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5200 Eastern Ave. 21224 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Shakib Baroody | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha S. Lacks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-14-1908 | | | 17. INFORMANT
Mr. Roy Saunders | | | ADDRESS
5 Clementine Ct. Balto., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) febrile respiratory illness
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Huntingtons Chorea | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12/85 to 2/12/85 , that (I) (we) last saw the deceased alive on 2/12/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Susan Penman MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2-12-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Susan Penman | | | | | | 22e. ADDRESS
5200 Eastern Ave Balt Md 21224 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
2/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of fact.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William Webster Sauter | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 2, 1985 | | 2b. HOUR
9 ¹⁰ A M |
| 3. SEX
male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
2/7/1904 | 6. AGE (IN YEARS (LAST BIRTHDAY))
80 YRS | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer | 12b. KIND OF BUSINESS OR INDUSTRY
self-employed | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Woodlawn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6748 Windsor Mill Rd. 21207 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Truman Sauter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Lulu Zimmerman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
No -- | | 16b. SOCIAL SECURITY NO
218-36-4479 | 17. INFORMANT ADDRESS
Baltimore, MD 21207
Mrs. Sara Sauter 6748 Windsor Mill Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bradycardia followed by cessation of heart.
DUE TO, OR AS A CONSEQUENCE OF
(b) colon carcinoma and bladder carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) with liver metastasis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION
1/19/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Colon Carcinoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 13, 19 85 to February 2, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 2, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Ronald M. Locke M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
2/2/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ronald M. Locke, M.D. | | 22e. ADDRESS
Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-5-85 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Maus. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors, Inc. | | 25a. DATE REC'D BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |
| 8728 Liberty Rd. Randallstown, MD 21133 | | | | | |

Letter

Number

Baltimore City

Colon carcinoma and bladder carcinoma

via liver metastasis

February 2 1955

Maryland General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 7 4

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWIN VICTOR SAVAGE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 24 1985 | | 2b. HOUR
2:40 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 12 13 | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | 12b. KIND OF BUSINESS OR INDUSTRY
Closure | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
August Savage | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Augusta Kressler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-01-0695 | | 17. INFORMANT
ADDRESS
Mrs. Margaret M. Savage, 3027 Eastern Ave.
Baltimore, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) LEFT LOWER LOBE PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c) RIGHT HEMIPLEGIA

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

| | | | |
|---|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
24 | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 7, 19 85</u> to <u>FEBRUARY 24, 19 85</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 24, 19 85</u> , and that in <u>(my/our)</u> opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Mukesh Luhar</u> | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
FEB 24 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MUKESH LUHAR, MD | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N.N. BROADWAY, BALTIMORE, MD 21231 | |

| | | | |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-28-85 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME
Ann S. Matthews, 3021 Eastern Ave., Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | |

REGISTRAR'S SIGNATURE
Fuka Davidson Nordall



X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MICHAEL A Scarangelo | | | | | 2a DATE OF DEATH MONTH DAY YEAR
2 09 85 | | | 2b HOUR
6 45 PM | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
04 17 75 | | 6 AGE (IN YEARS LAST BIRTHDAY)
9 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
none | | 12b KIND OF BUSINESS OR INDUSTRY
none | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN
MD BALTO LUTHERVILLE | | | | | 13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c STREET ADDRESS / ZIP CODE
8509 WESTFORD ROAD 21093 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Frank J. SCARANGELLO | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE
JoAnn M. ROMANSKI | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS
Family Records | | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Intravascular Coagulation
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Seizures, Mental Retardation | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-9 9PM 19 85 to 2-9 7PM 19 85 that (I) (we) last saw the deceased alive on 2-9-85 6PM, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE N. Seiden MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 2-9-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. SEIDEN MD | | | | | 22e. ADDRESS 22 S. Greene St. Balto, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE FEB 12, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Dubansky VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
EVANS CHAPEL OF CHIMES 2325 York Road | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP

93013 NO 1000 0.002

NO 1000

NO 1000

NO 1000



Department of Health

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Department of Health

D. C. Department of Health

Department of Health

Department of Health

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 7 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES JAMES SCHAEFER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 10, 1985 | | 2b. HOUR
M
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 2, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2013 Woodbourne Ave. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Acme Market- Manager | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Schaefer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Vomastek | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 212-18-3539 | | 17. INFORMANT ADDRESS
Mr. James S. Schaefer 323 St. Dunstan's Rd. 21212 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

CHRONIC**ALCOHOLISM**

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 77 to 6/8 19 85 that (I) (we) last
saw the deceased alive on 6/8 19 85 and that in (my) (our) opinion death occurred on the date and hour (and from the causes stated
above, (I) (we) (did) (did not) saw the body after death. | | | |
| 22b. SIGNATURE
Luis E. Rivera | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
2/11/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Luis E. Rivera, M.D. | | 22e. ADDRESS
5317 Bel Air Rd. | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | 23b. DATE
2-13-85 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 13 1985 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
DARREN J. SCHAFER | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 2-11-85 | | 2b. HOUR
10:53 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8-16-68 | 6. AGE (IN YEARS)
LAST BIRTHDAY
16 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2-11-85 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6523 Rosemont Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Balto., City | | 13c. STREET ADDRESS
6523 Rosemont Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William J. Schaffer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna C. Fuller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-86-7368 | | 17. INFORMANT
ADDRESS
William Schaffer, 6523 Rosemont Ave
Balto., MD 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? 2-11-85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject found hanging | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, OR OUTDOOR ETC.)
garage | | 21f. LOCATION
CITY OR TOWN STATE
Baltimore, Maryland | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2-11-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-15-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | |
| 24. FUNERAL DIRECTOR
John C. Miller, Inc. | | ADDRESS
6415 Belair Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 & 6 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1



Q3814 M01100 X002

Q3814 M01100 X002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04 / 7 85

| | | | |
|---|---|---|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Frederick August Schach | | 2a. DATE OF DEATH MONTH DAY YEAR 2 14 85 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1 22 04 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. AGE (IN YEARS LAST BIRTHDAY) 81 80 YRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer | 12b. KIND OF BUSINESS INDUSTRY Press Lord Balto. |
| 13a. STATE MD | 13b. COUNTY BALT | 13c. CITY OR TOWN BALT | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Gottleib Schaich | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Griens | 16. SOCIAL SECURITY NO. 215 01 3418 | |
| 17. INFORMATION ADDRESS 3103 Jackson Ridge Ct. 21131 | 18. NAME OF DECEASED Frederick B. Schaich | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral pulmonary ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CVA
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 14 84 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (hus) hospital attended the deceased from 2/14 1985 , to 2/14 85 , that (I) (we) lost saw the deceased alive on 2/14 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Step J. Romell | DEGREE | 22c. DATE SIGNED 2/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Romell MD | 22e. ADDRESS 2201 Argonne Dr Balt Md 21210 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE Feb. 18, 1985 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. |
| ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | 25a. DATE REC'D. BY REGISTRAR FEB 15 1985 | 25b. REGISTRAR'S SIGNATURE Jane Davidson-Randell |

BP

1

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

FILE NO. [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

4. [Illegible]

5. [Illegible]

5. [Illegible]

6. [Illegible]

6. [Illegible]

7. [Illegible]

7. [Illegible]

8. [Illegible]

8. [Illegible]

9. [Illegible]

9. [Illegible]

10. [Illegible]

10. [Illegible]

11. [Illegible]

11. [Illegible]

12. [Illegible]

12. [Illegible]

13. [Illegible]

13. [Illegible]

14. [Illegible]

14. [Illegible]

15. [Illegible]

15. [Illegible]

16. [Illegible]

16. [Illegible]

17. [Illegible]

17. [Illegible]

18. [Illegible]

18. [Illegible]

19. [Illegible]

REC'D
JUL 11 1962
FBI - PHOENIX

John C. Miller Inc-117 Bellvue St.-21506

Quinal 2-4-62 (First letter from John C. Miller)

Re: Miller, John C. (aka)
Miller, John C. (aka)
Miller, John C. (aka)

X ✓ X

Quinal 2-4-62 (First letter from John C. Miller)

21-03-157 Mr. James H. Schmitt-2008 E. Bellvue St. Phoenix 24

Letter from James H. Schmitt

25-4-62 Mr. James H. Schmitt-2008 E. Bellvue St. Phoenix 24

Explosion-Edward Miller

2-4-62
2-4-62

7-1-62-17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 8 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARIE B. SCHAUB | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 10 85 | | 2b. HOUR
6:30 PM |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
12/10/09 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. | 9. CITIZEN OF WHAT COUNTRY?
USA | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 11. CITY OR TOWN OF DEATH
Baltimore | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 13a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cashier | 13b. KIND OF BUSINESS OR INDUSTRY
Pantry Pride | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
14a. STATE
Md. | | | 14b. COUNTY
- | 14c. CITY OR TOWN
Balto. | 14d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 15. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Schmidl | | | 16. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Miller | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES, NO OR UNKNOWN
No | | 17b. SOCIAL SECURITY NO.
217-09-2254 | | 17. INFORMANT ADDRESS
William Herb, 1901 Forest Crt., Timonium, Md. 21093 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic adenocarcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) adenocarcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
myocardial infarction | | | | | |
| 19a. DATE OF OPERATION
2-4-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
intestinal obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Feb 10 , 19 85 , that (I) (we) last saw the deceased alive on Feb 10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Lanette Linthicum | | DEGREE
M.D. | | 22c. DATE SIGNED
2-10-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lanette Linthicum | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Crematory, Balto., Md. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Md. | | 23e. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 23f. REGISTRAR'S SIGNATURE
G. Davidson | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 8 1

FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARTHA M. SCHAUB | | | 2a. DATE OF DEATH
2/16/85 YEAR
02 16 85 MONTH DAY
6:00 AM HOUR | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 18 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. STATE
Md. | | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
212-74-2406 | | 17. INFORMANT ADDRESS
Dorothy Schaub (dghtr) same address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac - respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) a. Cldosis
DUE TO, OR AS A CONSEQUENCE OF
(c) ischemic bowel | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
RL pneumonia | | | | |
| 19a. DATE OF OPERATION
2/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (this hospital) attended the deceased from 2/13 , 19 85 , to 2/16 , 19 85 , that (we) lost
saw the deceased alive on 2/16 , 19 85 , and that in (our) opinion death occurred on the date and hour and from the causes stated
above. (d) (did) (did not) view the body after death. | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey A. Cool | | 22c. DATE SIGNED
2/16/85 | | 22d. ADDRESS
Union Memorial Hospital |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | 23b. DATE
2/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc. | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
William R. Riddle | | |

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CHICAGO, ILL. 1914

RECEIVED

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CHICAGO, ILL. 1914

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COPIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 5 0 4 7 8 2 | | | |
|---|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Baby Boy Scher | | | | 2a. DATE OF DEATH MONTH DAY YEAR
1 16 85 | | 2b. HOUR
11 ³² AM | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
1 16 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
0 YRS. 1 37 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
— | |
| 12b. KIND OF BUSINESS OR INDUSTRY
— | | 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
— | | 14. FATHER'S NAME FIRST MIDDLE LAST
David Scher | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Carol Lyn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
— | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
— | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extreme prematurity
DUE TO, OR AS A CONSEQUENCE OF (b) —
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
— | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
— | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK
— | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION CITY OR TOWN COUNTY STATE
— | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9:55A 1/16/85, 19 85, to 11:32A 1/16/85, 19 85, that (I) (we) lost saw the deceased alive on 11:32A 1/16 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Stephen L. Kinsman M.D. | | | | DEGREE
— | | 22c. DATE SIGNED
1/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen L. Kinsman | | | | 22e. ADDRESS
Sinai Hospital, Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
1-23-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Sinai Hospital | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME
SINAI Hospital | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

3

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

44-38861-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
CHARLOTTE C. SCHERCH | | | | 20. 2/7/85 | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
9 13 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
69 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U of Md Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Nursing Asst. | | 12b. KIND OF BUSINESS OR INDUSTRY
Hammons Lane N.H. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George Romoser | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Louise Raycob | | 13e. STREET ADDRESS / ZIP CODE
9484 Seven Courts Dr. 21236 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-03-9582 | | 17. INFORMANT ADDRESS
Ron C. Scherch 9484 Seven Courts Dr. 21236 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration Pneumonic
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Nine hours | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Necrotizing vasculitis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. Antos MD | | | | 22c. DATE SIGNED
2/7/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. Antos MD | |
| 22e. ADDRESS
Univ. Md Hosp, Balto, MD | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | | | 24b. ADDRESS
21229 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 8 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Ellen Schilling | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-24-1985 | | | 2b. HOUR
9:50 A.M. | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-10-06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. UNDER 1 YEAR
MONTHS DAYS
YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3100 Grindon Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Librarian | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3100 Grindon Ave. 21214 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert L. P. Evans | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Inez | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-40-6030 | | 17. INFORMANT
ADDRESS Towson, Md. 21204
Rev. Stephen M. Anderson, 702 Fairway Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/4 , 19 85 , to 2/24 , 19 85 , that (I) (we) last saw the deceased alive on 2/4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Francis X. Carmody | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francis X. Carmody, M.D. | | | | | | 22e. ADDRESS
3201 N. Charles St. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
2-26-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John R. Ruck | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DO NOT

RECEIVED



DO NOT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|---|---|----------------------------------|---|--|
| FOR
1- STATE
REGISTRAR | | | REG. NO. | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR |
| RITA Lillian SCHIMPF | | | | | | 2/20/85 | | | 8:35 P M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 1 MRS. | |
| Female | White | MONTH DAY YEAR
6 29 23 | | 61 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NY | USA | | | Balt City MD | | | | | |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore City | Univ of Maryland Hosp | | | Retired | | | CIA | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b INSIDE CITY LIMITS? | | 13c STREET ADDRESS / ZIP CODE | | | | |
| MD PG Greenbelt | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7710 Hanover Parkway | | | 20770 | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST
Elmer AMI Sheldon | | | FIRST MIDDLE LAST
Mary C Blank | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | |
| Yes | | | W.W.II | | 85-22-2146 Patrick Schimpf (Son) Annapolis, Md. 21403 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a
SR Coronary Artery Bypass | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 2/20/85 | | | Coronary Artery Disease | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/19, 19 85, to 2/20, 19 85, that (I) (we) lost saw the deceased alive on 2/20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | DEGREE | | | 22c DATE SIGNED | | | |
| BA Collins MD | | | | | | 2/20/85 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e ADDRESS | | | | | | |
| BA Collins MD | | | 117 Md Hosp 22 S. Greene St. Balt. | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | |
| Cremation | | | 2/23/85 | | Ft. Lincoln Cemetery | | Brentwood P.G. Maryland | | |
| 24 NAME OF FUNERAL HOME, P.A.
4739 Baltimore Ave. Hyattsville, Md. 20781 | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| | | | | | | FEB 28 1985 | | G. H. Davidson | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-----------------------------|--|---|---|---|--|---|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles G. Schmidt, Jr. | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-13 1985 | | 2b. HOUR
M 11:48
P. M | | | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR 12 17 24 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 60 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2-13 1985 | | 2d. HOUR
M 11:48
P. M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Radar Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Nat'l Guard | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Anne Arundel | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8 Patapsco Road 21090 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles G. Schmidt Sr | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Zethmeier | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-20-4413 | | 17. INFORMANT
Marion E. Schmidt | | | | ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ethanolism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | TITLE (SPECIFY)
Assistant | | | DATE SIGNED
2-14-85 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2-24-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process Inc | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
McGully Funeral Home of Brooklyn Baltimore Md 21245 | | | ADDRESS
237 East Patapsco Ave | | | 25a. DATE REC'D BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Randall | | | |

ОБЩЕ-МИНЕРНО

СИДН ПОТНОДЪ КОД

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 8 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Henry P. Schminke, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 85 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 3 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3719 Fleetwood Ave. 21206 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret.-Security Gd. | | 12b. KIND OF BUSINESS OR INDUSTRY
Masonic Temple | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3719 Fleetwood Ave. 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry P. Schminke, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-10-6436A | | 17. INFORMANT
ADDRESS
21234
Kenneth J. Schminke, Sr. 1812 Edgewood Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis, bladder inv.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>onset 1976</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Hypertensive Atherosclerosis (CHD)</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> 19 <u>85</u> , to <u>2-13</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-6-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>W. C. Ebeling MD</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>2-13-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm. Carl Ebeling MD (828-0235) | | | | 22e. ADDRESS
St. Jos. Prof. Bldg. 7401 Osler Dr. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
BALTO MD 2123 FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson Randall</u> | | | |

BP



2-13-63

Memphis, TN

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White

Male

Memphis, TN

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Memphis, TN

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Memphis, TN

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Memphis, TN

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET ANNA SCHORBACK | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 2 85 | | 2b. HOUR
6:58 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 17 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89
YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred Lawrence | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen O'Neil | | 16. SOCIAL SECURITY NO.
213-74-8221 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-74-8221 | | 17. INFORMANT
ADDRESS
Edwin J. Schorback 2921 Michigan Ave. 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hr | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure | | | | | | 1 1/2 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Carcinomatosis | | | | | | 1 1/2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION
1/25/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Abdomen | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
G. Michael Meyer | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/2/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Michael Meyer | | | | 22e. ADDRESS
St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



UNITED STATES DEPARTMENT OF AGRICULTURE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Ella Schramm</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>2 10 85</i> | | | 2b. HOUR
<i>1:50</i> M | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Dec. 3, 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>89</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Reswick</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Nurse</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Medical</i> | |
| 13a. STATE
<i>Florida</i> | | 13b. COUNTY
<i>Sarasota</i> | | 13c. CITY OR TOWN
<i>Sarasota</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
<i>201 First St. 33577</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Walter A. Schramm</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Katherine Horan</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>090-32-4587</i> | | 17. INFORMANT
ADDRESS
<i>Walter E. Williams 418 Edgewater Rd. Pasadena, Md. 21122</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>2-3 weeks</i>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>Dec 31 19 84</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>700 W. 40th St. Baltimore 21211</i> | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 31 19 84</i> to <i>FEB 10 19 85</i> , that (I) (we) lost
saw the deceased alive on <i>FEB 10 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (do not) view the body after death. | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>W.B. Daniels, Jr</i> | | 22c. DATE SIGNED
<i>2/10/85</i> | | 22d. PHYSICIAN'S ADDRESS
<i>700 W. 40th St. Baltimore 21211</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Feb. 14, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Johns</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Queens, New York, New York</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Mitchell-Wiedefeld Home, Inc.</i> | | ADDRESS
<i>6500 York Rd. Balt. Md. 21212</i> | | 25a. DATE REC'D BY REGISTRAR
<i>FEB 19 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>ie Davidson-Rodell</i> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



the date of the meeting was the 1st of May 1947

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 9 0

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELSIE E. SCHRAMM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 85 | | | 2b. HOUR
4 50 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 9 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4001 4th Street, Baltimore 21225 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John LERP | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Augusta Bierly | | | ADDRESS
9248 Limostone Place College Park, MD 20740 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
216125959 | | 17. INFORMATION
CARL Schramm | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aspiration
DUE TO, OR AS A CONSEQUENCE OF
(c) Pseudo Bulbar Palsy
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Paget's Disease | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/29 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/85 to 2/24/85 , that (I) (we) last saw the deceased alive on February 24 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Michael Glanis | | | DEGREE | | | 22c. DATE SIGNED
2/24/85 | | 22d. ADDRESS
3001 S. Hanover Street South Baltimore General Hosp | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
2-27-85 | | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR Hill Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BROOKLYN A.A. MD | |
| 24. FUNERAL DIRECTOR
NAME
MCCULLY FUNERAL Home | | | ADDRESS
237 E Patapsco Ave BALT MD 21225 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|
| 1. STATE REGISTRAR Harry N. Schrieber | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
SCHRIEBER HARRY N | | | | 2b. HOUR
11:45p | | | |
| 3 SEX
Male | | | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
November 15 1918 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | | | 7. IF UNDER 1 YEAR MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS HOURS MIN.
0 0 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth.Steel | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
722 S. Conkling St. 21224 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert Lee Schrieber | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mable Crist | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no --- | | | | 16b. SOCIAL SECURITY NO.
218-05-3698 | | 17. INFORMANT ADDRESS
Theresa Schrieber 722 S. Conkling St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF (c) Probable Cerebrovascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
23 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 16, 1985 to FEBRUARY 22, 1985 that (I) (we) last saw the deceased alive on FEBRUARY 22, 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death) | | | | | | | |
| 22b. SIGNATURE GARY WAND DEGREE | | | | 22c. DATE SIGNED 24, 1985 | | 22d. REGISTER'S SIGNATURE Davidson | |
| 22e. ADDRESS 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231 | | | | 22f. REGISTER'S SIGNATURE Davidson | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 27 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME
Lilly & Zeiler, Inc | | | | 24b. ADDRESS
700 S. Conkling St. | | 25a. REGD. BY REGISTRAR FEB 27 1985 | |

RECEIVED
JAN 10 1968



FILED 7 1968
JAN 10 1968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|------------------|---|--|---|---|---|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mildred M. Schuh | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2 13 19 85 | | | 2b. HOUR
M
6:40A | | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9-29-04 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
80 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 13 19 85 | | | 2d. HOUR
M
6:40A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3807 Ridgescroft Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3807 Ridgescroft Rd. - 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida | | | 16. ADDRESS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
213-50-8077
218-32-1409B | | 17. INFORMANT
Paul L. Schuh - 3907 Ridgescroft Rd. - 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
2/13/85 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc-6415 Belair Rd.-21206 | | | ADDRESS
6415 Belair Rd.-21206 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



1851-1852

1853

1854-1855



NOTES ON THE HISTORY OF THE

1856

1857

1858

1859

1860-1861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. 85 04793 | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) FRANK SCHULTZ | | | | | 2a DATE OF DEATH
MONTH DAY YEAR HOUR
2 15 85 10:30 AM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
April 12 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Messenger | | 12b KIND OF BUSINESS OR INDUSTRY
Credit Union | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
2428 Fait Ave. 21224 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Christian Schultz | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Schriner | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
---- | | 17 INFORMANT
Carrie Schmeisser | | ADDRESS
21224 2428 Fait Ave | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/1 , 19 85 to 2/15 , 19 85 , that (I) (we) last saw the deceased alive on 2/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
KIN SING | | | | | DEGREE
MD | | | 22c DATE SIGNED
2/15/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
KIN SING | | | | | 22e ADDRESS | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
Feb. 17 '85 | | 23c NAME OF CEMETERY OR CREMATORY
1st Un Evangelical Church Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR
Lilly & Zeiler, Inc | | | | | 25a DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04794

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
Fannie Schutz | | 2a DATE OF DEATH
MONTH DAY YEAR
2-8-85 | | 2b HOUR
1:23 PM | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
10 20 89 | | 6 AGE (IN YEARS LAST BIRTHDAY)
95 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
Maryland | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital of Maryland | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD. | | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Baltimore | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catonville, Maryland 21228 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b SOCIAL SECURITY NO.
219-54-3415 | | 17 INFORMANT
ADDRESS
Mrs. Hilda S. Weissman
801 Painted Post Court, 21208 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sepsis pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 2-7- 19 85 , to 2-8- 19 85 , that (I) (we) last saw the deceased alive on 2-8- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Mathew | | DEGREE | | 22c DATE SIGNED
2-8-85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
A. Mathew | | 22e ADDRESS
Lutheran Hospital, 730 Ashbaker St. Baltimore | | | |

| | | | |
|---|----------------------------|---|---|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b DATE
2/10/85 | 23c NAME OF CEMETERY OR CREMATORY
Hebrew Friendship | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24 FUNERAL DIRECTOR
NAME
8728 Liberty Rd. Randallstown, MD. 21133
Loring Byers Funeral Directors, Inc. | | 25a DATE REC'D. BY REGISTRAR
FEB 11 1985 | 25b REGISTRAR'S SIGNATURE
Gelia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



34

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the burial/interment. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504795

| | | | |
|--|---|--|--|
| 1- STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
BEATRICE SCHWARTZ | | 2a. DATE OF DEATH MONTH DAY YEAR
02 09 1985 2b. HOUR
7:30p.m. | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
02 14 18 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 6. AGE (IN YEARS LAST BIRTHDAY)
68 66 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF BUSINESS OR VOCATION, INCLUDING LIFE)
MANTICURIST | | 12b. KIND OF BUSINESS OR INDUSTRY
BEAUTY SHOP | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD 13b. COUNTY
BALTO. 13c. CITY OR TOWN
BALTIMORE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
714 CLIFFEDGE ROAD Balt. 21208 | |
| 14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DAVID FRIEDMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BESSIE MATZ | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO 16b. SOCIAL SECURITY NO.
218-66-0923 | | 17. INFORMANT ADDRESS
MR. LOUIS SCHWARTZ 714 CLIFFEDGE RD. BALTO., MD 21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Hypotension
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF immunocompromised state due to sarcoidosis. ? malignancy
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Abdomen | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
STREET | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
partial YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21d. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/28/85 19 85 to 2/09 19 85 , that (1) (we) lost saw the deceased alive on 02/09 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Uma Prasad | | 22c. DATE SIGNED
02/09/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
UMA PRASAD | | 22e. ADDRESS
SINAI HOSPITAL, Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 11, 1985 | |
| 23c. NAME OF CEMETERY OR CREMATOR
BALTIMORE HEBREW | | 23d. LOCATION
REISTERSTOWN BALTO. MD | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25. DATE REC'D BY REGISTRAR
FEB 19 1985 | |
| 26. REGISTRAR'S SIGNATURE
Davidson-Randall | | 27. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04796

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PAULINE S SCHWARTZ | | 2a. DATE OF DEATH MONTH DAY YEAR 02-20-85 | | 2b. HOUR 8A. M. | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 10 19 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | 7b. CITIZEN OF WHAT COUNTRY? XXXX USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST TZODECK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL DEMB | | 13e. STREET ADDRESS APT. D 6514 PARK HTS. AVE. #21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-14-3900 | | 17. INFORMANT PAUL H. SCHWARTZ APT. D 6514 PARK HTS AVE. BALTO., MD 21215 | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) SEPTICEMIA | | 2 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA | | 1 wk |
| DUE TO, OR AS A CONSEQUENCE OF (c) RECURRENT CEREBROVASCULAR Acc | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

UN CONTROLLED Diabetes mellitus.

| | | | | | |
|---|--|---|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-21 19 85 to 02-20 85 , that (I) (we) last saw the deceased alive on 02-20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED 02-20-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B-ZAW-WIN, MD. | | 22e. ADDRESS LEVINDALE GERIATRIC GR BALTO MD 21215 | | | |

MEDICAL CERTIFICATION

| | | | |
|---|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE FEB. 21, 1985 | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | 25a. DATE REC'D. BY REGISTRAR FEB 22 1985 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------|------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
Carey Donnel Scott | | | XX MONTH DAY YEAR
2-2 19 85 | | | 2b. HOUR
1:12 a. M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| male | black | 3 1 64 | 20 YRS. | MONTHS DAYS | HOURS MIN | Baltimore City, MD. | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Georgia | | U.S.A. | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 3202 Ferndale Avenue | | | | | | | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | |
| Maryland | | | Baltimore | | | 4304 Main St. 21227 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| Major Scott | | | Martha I. Nix | | | N/A | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| NO | | | N/A | | | Apt. 3 Orlando Scott 720 Reservior St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Narcotism</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>Dennis F. Smyth</u> | | | | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 2-2-85 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | | 2/8/85 | | Md. National Mem Pk. | | Laurel, Md. | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. | | | | | ADDRESS 1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| | | | | | FEB 6 1985 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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100% COTTON FIBRE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 9 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LONNIE SEABERRY Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 12 85 | | 2b. HOUR
3:00a M |
| 3. SEX
m | 4. RACE
Col | 5. DATE OF BIRTH
MONTH DAY YEAR
12 17 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Dunn n.e | 7b. CITIZEN OF WHAT COUNTRY?
MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lock Raven V. A. Hosp. retired | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Gov. | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
md | 13b. COUNTY
Balls | 13c. CITY OR TOWN
Balls | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE
2328 Harlem ave 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lonnie Seaberry Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alberta Fuller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
217-16-4834 | | 17. INFORMANT
Delores Seaberry ADDRESS
2338 Harlem ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a). CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b). METASTATIC CARCINOMA PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
(c). | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION
2/12/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 25 19 85 to FEBRUARY 12 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 12 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bhupinder Singh MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/12/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BHUPINDER SINGH | | 22e. ADDRESS
LRVAH | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
B | 23b. DATE
2/16/85 | 23c. NAME OF CEMETERY OR CREMATORY
Western Shan | | 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE
Balls md | |
| 24. FUNERAL DIRECTOR
NAME
Joseph C. Rues | | ADDRESS
2222 W. North ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | 25b. REGISTRAR'S SIGNATURE
[Signature] |



X

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 7 9 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Seeds Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 1985 | | | 2b. HOUR
11:30 A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 11 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hamilton Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Railroad | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Export Agent | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Lutherville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Seeds | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Happ | | 16. STREET ADDRESS
509 College Ave. 21093 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
705-09-4629 | | 17. INFORMANT
ADDRESS
Mr. William Seeds -6675 Loch Hill Rd. 21239 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular Accident (L)
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 110
Pneumonia (D) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-29-85, to 2-11-85, that (I) (we) last saw the deceased alive on 02-21-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Cesar Gamboa M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
2-21-85 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Cesar Gamboa | | 22f. ADDRESS
3440 BelAir Rd. 21213 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home Inc. | | ADDRESS
1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|-------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| James | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
| James | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504800

| | | | |
|--|--|--|---|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
GEORGE KENNETH SEIFERT | | 2a DATE OF DEATH MONTH DAY YEAR
2-3-85 7 ⁰⁰ PM | |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5 DATE OF BIRTH MONTH DAY YEAR
10-3-25 | 6 AGE (IN YEARS LAST BIRTHDAY)
59 YRS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Educator | 12b KIND OF BUSINESS OR INDUSTRY
Schools Balto City |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Anthony Seifert | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Marie Cavanaugh | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WW II .219-10-0614 | |
| 17 INFORMANT | | ADDRESS
Bernard A. Sulewski Same as 13 e | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acquired Immune Deficiency Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cytomegalovirus Pneumonia (Bilateral)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cytomegalovirus Encephalitis</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-4-</u> 19 <u>84</u> to <u>2-3-</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>2-3-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Philip M. Lam | | 22c. DATE SIGNED
2-5-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP M. LAM | | 22e. ADDRESS
ST. AGNES HOSPITAL, BALTIMORE MD 21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/7/85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto Balto Md | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | |

FOR
1 - STATE
REGISTRAR

Unknown #85-10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------|---|-------------------|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| HAROLD Sellers | | 2/ 4/ 1985 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| MALE | BLACK | 12 25 49 | 35 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| NEW YORK CITY | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | 200 Emory St. | | SALESMAN | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| AUTO | | 99999 | | HARTSVILLE | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| ARTHUR SELLERS | | ULA MAE | | (YES) (UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| 248-82-6270 | | EARTHLYN R. SELLERS | | PART I DEATH WAS CAUSED BY: | |
| | | HARTSVILLE, S. CAR. Rt6, Box60 | | IMMEDIATE CAUSE (a) Gunshot Wound of Head and Chest | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | APPROX. HOUR A.M. MONTH DAY P.M. | | subject shot | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | trunk of car | | 200 Emory St., Balto. City, Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Gregory R. Kauffman, M.D. | | M.D. Assistant | | 2/6/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 2/10/85 | | NEW HOPEWELL BAP. CH. | |
| 24. FUNERAL DIRECTOR NAME | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | |
| LEROY O. DYETT | | CITY OF BALTIMORE | | BALTIMORE | |
| 4600 LIBERTY HGTS. AVE. | | SOCIETY HILL, S. CAR. | | FEB 8 1985 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

40% COTTON FIBER

DAVID

WALKER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, shows only injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|---|---|----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MARY
MIDDLE CATHERINE CATHERINE
LAST SHAFER SHAFER | | | 2a. DATE OF DEATH
MONTH FEB. 2, 1985
DAY Feb 2, 1985
YEAR 1985 | | 2b. HOUR
1025 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH JULY
DAY 8, 1921
YEAR 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESLER (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE |
| 13a. STATE
MD | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
GLEN BURNIE | |
| 14. FATHER'S NAME
FIRST BENJAMIN
MIDDLE
LAST HALL | | | 15. MOTHER'S MAIDEN NAME
FIRST ELIZABETH
MIDDLE
LAST SCHANTE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (HUSBAND) ADDRESS
CHARLES C. SHAFER SAME AS 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arterio sclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years
years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Chronic Renal Failure | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 27, 1985, to Feb 2, 1985, that (I) (we) lost saw the deceased alive on Feb. 2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Russell J. Stankiewicz | | DEGREE
MD | | 22c. DATE SIGNED
Feb 3, 1985 | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
Russell J. Stankiewicz | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 6, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PARK | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MD. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME SINGLETON FUNERAL HOME GLEN BURNIE, MD | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | |

20% COTTON LITE

WILSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
THOMAS J. SHANAHAN SR. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEBRUARY 12, 1985 | | 2b. HOUR
3:40 AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
OCTOBER 8, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
89 | | 7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
IRON WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | | 13b. CITY OR TOWN
BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Michael Shanahan | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
115-12-6557 | | 17. INFORMANT ADDRESS
GERALDINE RANAZZO 931 Rosedale Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
CEREBROVASCULAR ACCIDENT ORGANIC BRAIN SYNDROME URINARY TRACT INFECTION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from FEBRUARY 4, 1985 to FEBRUARY 12, 1985 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on FEBRUARY 12, 1985 , and that in (my <input checked="" type="checkbox"/> your) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
C.S. Ramsey D.O. | | | | DEGREE | | 22c. DATE SIGNED
2/12/85 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C.S. RAMSEY D.O. | | | | 22e. ADDRESS
CHURCH HOSPITAL
100 NORTHERN BROADWAY 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
Feb. 13, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Parkville Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME
HARTLEY Miller Funeral Home | | | | ADDRESS
7527 Harford Rd. | | 25a. DATE REC'D BY REGISTRY
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION



Handwritten vertical text or symbols, possibly a list or index, located in the middle-left section.

Handwritten text or symbols, possibly a list or index, located in the middle-left section.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or if a medical examiner must be notified by law.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DOROTHY SHAPIRO | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11, 1985 | | | 2b. HOUR
07:58pm | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 16, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK, (AT MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2300 LYNDBURST AVE. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATHAN KRAMER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESSIE COHEN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-18-7197 | | 17. INFORMANT
MR. ALAN SHAPIRO
2300 LYNDBURST AVE. BALTO., MD 21216 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pseudomonas Sepsis | | | | | | | | 6 days | |
| (c) Pseudomonas Pneumonia | | | | | | | | 6 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: M. tral Valve Disease - Congestive Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION
1/30/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
M. tral Regurgitation / Aortic Disease | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I (this hospital) attended the deceased from January 29, 1985, to February 12, 1985, that I (we) last saw the deceased on February 12, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Walter M. Morgan MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/12/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter M. Morgan MD | | | | 22e. ADDRESS
Johns Hopkins Hospital 600 N WOLFE ST. BALTO., MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 14, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH | | 23d. LOCATION
BALTIMORE COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | |

BP

91833

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|------------------------|--|---|--|--------------------------------|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Julian B. Sharpe II | | | | 2a DATE KNOWN OF DEATH
XX MONTH DAY YEAR
ESTIMATED <input type="checkbox"/> 2-1 19 85 | | | | 2b HOUR
M
10:43 p. M | |
| 3 SEX
Male | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
May 28, 1953 | 6 AGE (IN YEARS)
LAST BIRTHDAY
31 YRS. | IF UNDER 1 YR.
MONTHS DAYS
. | IF UNDER 24 HRS.
HOURS MIN. | 2c DATE PRONOUNCED DEAD
2-1 19 85 | | 2d HOUR
M | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
So. Carolina | | 7b CITIZEN OF WHAT COUNTRY
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2015 Bobhendrickson Court | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tank Mechanic | | 12b KIND OF BUSINESS OR INDUSTRY
Berdette Gas Produc | |
| 13a STATE
Md. | | 13b CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
2015 Bob Hendrickson Ct. | | 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julian B. Sharpe, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Burgess | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b SOCIAL SECURITY NO.
None | | 17. INFORMANT
(mother) ADDRESS
Mrs. Jessie B. Wilson Manning, S.C. | | | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stab wound of Chest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
29102 |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|---|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
10:15PM 2-1 19 85 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject was stabbed | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE
2015 Bobhendrickson Ct., Balto., Md. | |

| | | | | | |
|---|--|---|--|------------------------------|--|
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2-2-85 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | |

| | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
2/6/85 | | 23c NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Pinewood Sumter S.C. | |
| 24 FUNERAL DIRECTOR
NAME
Fleming E. Barnes | | | | ADDRESS
Benson, Md. | | 25a DATE REC'D. BY REGISTRAR
FEB 4 1985 | |
| | | | | | | 25b REGISTRAR'S SIGNATURE
<i>Lelia Davidson-Randall</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ARMED

MAINTAIN

RIGHT MOTION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|--|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BETTY M. SHAW | | | 2a DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 1, 1985 | | 2b HOUR
2:45^{PM} |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
03 07 23 | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE
Maryland | | 13c CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE
7516 Holabird Ave. 21222 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William Lemon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Goldie Spiker | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b SOCIAL SECURITY NO.
233-30-0540 | | 17 INFORMANT ADDRESS
Walter C. Shaw 7516 Holabird Ave. 21222 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **LUNG CARCINOMA**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | |
|--|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (the hospital) attended the deceased from JANUARY 29, 1985 to FEBRUARY 1, 1985 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on FEBRUARY 1, 1985 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Paul R Gormley</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>2/1/85</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL R GORMLEY | | 22e ADDRESS
CHURCH HOSPITAL
100 NORTH BROADWAY 21231 | | | |

| | | | |
|---|----------------------------|---|--|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
2-4-85 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Connely Funeral Home of Dundalk | | 25a DATE RECD. BY REGISTRAR
FEB 7 1985 | 25b REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Q4B 2 NOV 1953 KOD

11/11/53



11/11/53

11/11/53

11/11/53

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|--|---|---|---------------------------|---|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ida R. Shefferman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-18-1985 | | 2b. HOUR
M
M | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2-9-1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
93 | | 8. IF UNDER 24 HRS.
HOURS MIN.
93 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(GIVE WORK FOR MOST OF WORKING LIFE)
Read's Drug Store | | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4410 Forest View Ave., -21206 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Crossen | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
217-09-2435 | | 17. INFORMANT
ADDRESS
Mr. Alvin J. Shefferman - 4410 Forest View Ave - 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ATRIAL FIBRILLATION | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
NA | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 6/25 , 19 82 , to 2/18 , 19 85 , that (1) (we) last saw the deceased alive on 11/16 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (2) (3) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Rosemary Olivo MD DEGREE | | | | | | | | 22c. DATE SIGNED
2-18-85 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROSEMARY OLIVO MD | | | | | | | | 22e. ADDRESS
5807 HARFORD RD. BALT. MD 21214 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504808

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST ANNA MIDDLE ELIZABETH LAST SHELLEY
<i>Anna Elizabeth Shelley</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 9 85 | | 2b. HOUR
9 19 ^{AM} | |
| 3. SEX
F Female | 4. RACE
C White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 14 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Rhode Island | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. CITY OR TOWN
Stevenson | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Henry MIDDLE SHELLY LAST | | 15. MOTHER'S MAIDEN NAME
FIRST Susan MIDDLE Mansell LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
037-44-8417 | 17. INFORMANT ADDRESS
Villa Julie Infirmary, same as #13e | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Ilcus*

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/1</i> , 19 <i>85</i> , to <i>2/9</i> , 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>2/1</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Dorian St Martin</i> | DEGREE
M.D. | 22c. DATE SIGNED
<i>2/9/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dorian St Martin</i> | 22e. ADDRESS
<i>Mercy Hospital</i> | | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-13-85 | 23c. NAME OF CEMETERY OR CREMATORY
St. Ann Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cranston, Rhode Island |
|--|----------------------|--|--|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> |
|--|--|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR
1- STATE
REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---------|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | |
| FIRST MIDDLE LAST
Samuel Shellington | | | | | | | | | | MONTH DAY YEAR
2/11/ 19 85 | | | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | | | | | |
| Male | | Black | | MONTH DAY YEAR
11 6 84 | | LAST BIRTHDAY YRS
3 | | MONTHS DAYS | | HOURS MIN. | | 2/ 11/ 19 85 | | A M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Md. | | | | USA | | | | | | | | Baltimore City, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | | | Johns Hopkins Hospital | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | Balto. | | | | | | | | 1327 Chapel St 21205 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Samuel E. Shellington | | | | | | Annette Patterson | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| N/A | | | | | | N/A | | | | | | Annette Patterson 1327 Chapel St. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held (an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Noted Cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2/12/85 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | | | | | | | ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY | | | | | | | | | |
| Burial | | | | 2/15/85 | | | | Cedar Hill Cem. | | | | Anne Arundel Co., Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H 1101 E. North Ave. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

20% COTTON FIBER

DAVID WINTER



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|-------------------------|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Ulysess | | MIDDLE
F. | | LAST
Sheppard | | 2a. DATE OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 2 DAY 11 YEAR 1985 | | 2b. HOUR
10:16 M A | |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH 12 DAY 25 YEAR 1917 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 67 YRS. | | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH 2 DAY 12 YEAR 1985 | | 7d. HOUR
10:16 M A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2334 McCulloh Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2334 McCulloh St. | | | |
| 14. FATHER'S NAME
FIRST Richard MIDDLE Sheppard LAST Sheppard | | | | 15. MOTHER'S MAIDEN NAME
FIRST Beatrice MIDDLE Ware LAST Ware | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
220-09-6880 | | 17. INFORMANT
ADDRESS
Delaphine Watts 2311 Orem Ave. St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie J. Yhelle M.D. Assistant | | | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | DATE SIGNED 2/13/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cem. | | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Balto. Md. | | |
| 24. FUNERAL DIRECTOR
Chadman-Harris 1701 McCulloh St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
2-13-85 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | |

MEDICAL CERTIFICATION

W2

2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 5 0 4 8 1 1 | | | |
|---|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ellis H. Shifflett | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 25 85 | | 2b. HOUR
1:30 PM | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 3 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF EMPLOYED | |
| 13a. STATE
MD. | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ellis H. Shifflett SR | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Esther Perry | | 13e. STREET ADDRESS
3430 7th Street (21225) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
215 20 5403 | | 17. INFORMANT
Bernice Shifflett, 3430 7th St. (21225) | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HEMOPTYSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>METASTATIC CARCINOMA OF UNKNOWN PRIMARY</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 12, 19 85</u> to <u>February 25, 19 85</u> , that (I) (we) last saw the deceased alive on <u>February 25, 19 85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Byrnefeld, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert J. Neufeld | | | | 22e. ADDRESS
3001 S. Hanover St. Baltimore 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk., A.A.Co., Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Geo. J. Gonce, 4001 Ritchie Hg., Baltimore, Md. | | | | 25a. DATE RECD. BY REGISTRAR
FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

BP

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1/11/11

100%



FEB 26 1911

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--------|---|---|---|--------------------------|--|------------------------------|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST
Mildred | MIDDLE | LAST
Shifren | 2a. DATE OF DEATH
MONTH DAY YEAR
2 - 8 - 85 | | 2b. HOUR
4:00
A.M. | | |
| 3 SEX
Female | | 4 RACE
White/ Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-7-18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
19 N. WICKHAM RD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
19 N. Wickham Road 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AUGUST Goldstein | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE COHEN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-09-2878 | | 17. INFORMANT
MRS. LOIS MEYER
ADDRESS
9051 MEADOW HEIGHTS RD., RANDALLSTOWN, MD 21133 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
(condition existed 10 years)
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
"sudden" death | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-77, 19____, to 2-8-85, 19____, that (I) (we) last saw the deceased alive on 2/5/85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alfred J. Shulman, M.D. | | | | DEGREE
The Gundry Hospital, Inc.
2 N. Wickham Road, Balto., Md. 21229 | | | | 22c. DATE SIGNED
2/8/85 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-10-85 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO (ARLINGTON) | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

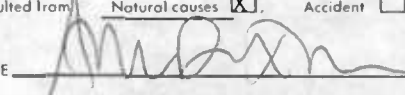
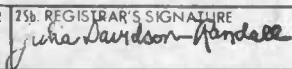
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 04813 | | | |
|---|--|------------------|--|--|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|---------------|--|----------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
RALPH G. SHINABERRY | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 22 19 85 | | | | | | | | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8/14/1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
56 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 22 19 85 | | | | | | | | | | 2d. HOUR
9:29 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1703 S. Hanover St. (21225) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Telephone | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1703 S. Hanover St. (21225) | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE
IRA S. SHINABERRY | | | | | | | | | | 15. MOTHER'S MAIDEN NAME MIDDLE
ELLA M. REED | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
YES | | | | (IF YES, GIVE WAR OR DATES)
1953-55 | | 16b. SOCIAL SECURITY NO.
212-22-4968 | | 17. INFORMANT ADDRESS (21122)
Clifton Shinaberry, 239 Magothy Bch Rd., Pasadena, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-23-85 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | | | | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Vet. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville, Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
George J. Gonce, 4001 Ritchie Hg., Balto. MD. 21225 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THELMA M. SHIPMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-18-85 | | 2b. HOUR
2:15 AM | |
| 3 SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 11 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse-Aide | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
255 Bunker Ave 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William James Davis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Davis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
213-32-9546 | | 17. INFORMANT
ADDRESS
High Shipman 255 Bunker Ave 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EXTENSION OF MYO CARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ISCHEMIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 13 , 19 85 , to FEB 18 , 19 85 , that (I) (we) last saw the deceased alive on FEB 18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Theodore Kramer | | DEGREE
MD | | 22c. DATE SIGNED
2-18-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THEODORE KRAMER, MD | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(IF CRY)
Burial - Transfer | | 23b. DATE
2/23/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olive | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elizabethtown N.C. | |
| 24. FUNERAL DIRECTOR
NAME
Funell B. Eden | | ADDRESS
1631 Druid Hill Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | |
| | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | | |

70 44 35 20 1 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DND

2-10-5

10-10-5

10-10-5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is not, any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

| Item 7-2-93 FilmG701 | | | | | STATE OF MARYLAND | | 8 5 0 4 8 1 5 | |
|--|--|--|--|--|---|---|--|--|
| 1- STATE REGISTRAR W.H. Per Informat | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | |
| FIRST MIDDLE LAST
JOEL S. SHOINTUCH | | | | | MONTH DAY YEAR
2/16/1985 | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR |
| Male | | White | | MONTH DAY YEAR
11-3-1942 | | 42 YRS | | 6 P M |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| BALTO, MD. | | USA | | | | Baltimore City | | MD. |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a US OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | University Hospital | | | | MANAGER
XXXXXXXXXXXX | | Advertisement |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c STREET ADDRESS / ZIP CODE | |
| Md. | | | | | Baltimore | | 8913 Winands Rd 21133 | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
HERMAN NMI SHOINTUCH | | | | | FIRST MIDDLE LAST
BERTHA B. STERN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | |
| YES NO | | | | | XXXXXXXXXX 213-40-0526 | | MRS. LINDA A. SHOINTUCH
8913 WINANDS RD. RANDALLSTOWN, MD 21133 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>multiple organ failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>metastatic renal cell carcinoma</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 2/4/85 | | Venous access for hyperalimentation | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) <u>this hospital</u> attended the deceased from <u>1-29</u> , 19 <u>85</u> , to <u>2-16</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>2-16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | 22c. DATE SIGNED | |
| Aysel K. Sanderson, MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | |
| Aysel K. Sanderson | | | | Univ. Hosp, 22. South Greene St. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| BURIAL | | FEB. 18, 1985 | | BOBROISKER BENEFICIAL | | CIR. ROSEDALE (BALTO. MD) | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| NAME SOL LEVINSON & BROS. INC. | | | | | | FEB 20 1985 | | Aysel K. Sanderson-Randall |
| 6010 REISTERSTOWN RD. BALTO. MD 21215 | | | | | | | | |

BP

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 1 6

FOR
1. STATE
REGISTRAR

REG. NO.

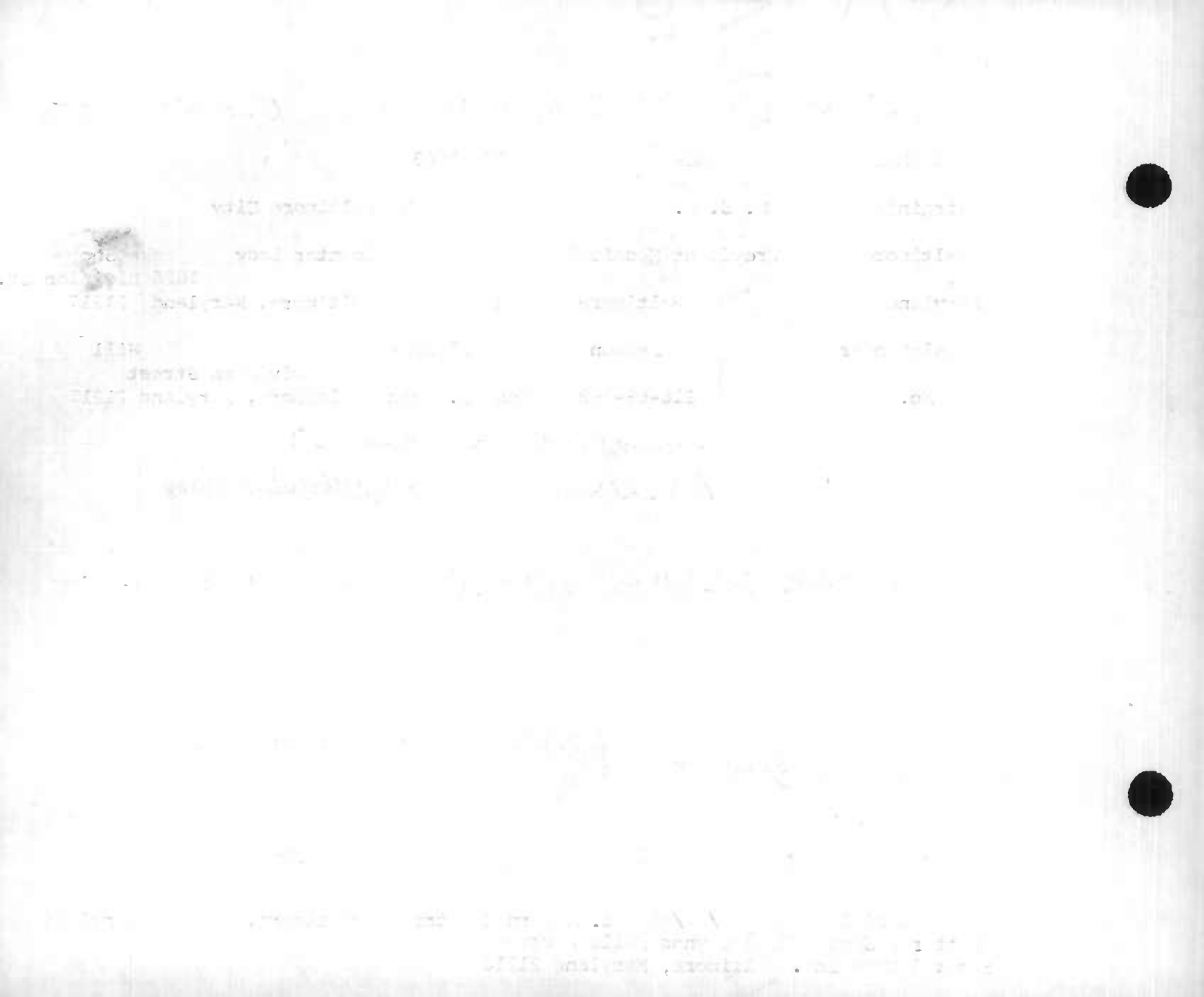
| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) L YDIA B SHORTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR 02-21-85 | | 2b. HOUR
1:05 P.M. |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR 4 30 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Counter Lady | | 12b. KIND OF BUSINESS OR INDUSTRY
Bake Shop |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STREET ADDRESS / ZIP CODE 1626 Division St. Baltimore, Maryland 21217 | | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexander Nelson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche Hill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO.
218-09-7629 | | 17. INFORMANT
Edna L. Ryan Baltimore, Maryland 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) MITRAL VALVULAR DISEASE . CONGESTIVE HEART FAILURE | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| MITRAL VALVULAR DISEASE . CONGESTIVE HEART FAILURE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 6 19 85 to FEBRUARY 21 19 85 , that (I) (we) last saw the deceased alive on FEB. 21 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
C.C. ONE JEME MD | | DEGREE MD | | 22c. DATE SIGNED
2-21-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C.C. ONE JEME MD | | 22e. ADDRESS
PROVIDENT HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S NAME
Nutter & Sons | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |
| 25c. ADDRESS
2501 Gwynns Falls Parkway
Funeral Home Inc. Baltimore, Maryland 21216 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified also.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 5 0 4 8 1 7 | | | | |
|--|--|--|-----------------------------|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MYRTLE O. SHRECK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
2 17 85 6 12 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
9 01 1947 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
37 | | 7b. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTO GENERAL HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OR LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR
Clothing | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
PASADENA | | 13d. STREET ADDRESS / ZIP CODE
8463 Geneva Rd. 21122 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
FRANK A. SHRECK | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SARAH Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
24-03-7637 | | 17. INFORMANT ADDRESS
William J. Schreck Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 2/19 19 85 , to 2/17 19 85 , that (b) (we) saw the deceased alive on 2/17 19 85 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If not (a) (did not) view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE DEGREE
Dr. Nelson M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | |
| 22c. DATE SIGNED
2/17/85 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NELSON LUGO M.D. | | | | | | | | | |
| 22e. ADDRESS
50. BALTO. Gen. Hosp. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rock Hall Kent Md | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 1 8

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lisa Sierra | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-4-85 | | | 2b. HOUR
4:40 PM | | | |
| 3 SEX
F | | 4 RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 19 83 | | 6 AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
1 1/2 YRS. | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7c. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Nt. Washington Pediatric Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
City/Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
324 S. COLLINGTON 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MIGUELL SIERRA | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Debbie LYNN CAUDILL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
212-04-8381 | | 17. INFORMANT
ADDRESS
Debbie L. Caudill 114 N. COLLINGTON | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
35 minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Febrile illness
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | 72 HRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Macrocephaly - cleft lip and palate. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb-02 , 19 84 , to Feb 04 , 19 85 , that (I) (we) lost saw the deceased alive on Feb 04 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Pedro P. Rodriguez | | | | | DEGREE
MD | | | 22c. DATE SIGNED
2/4/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pedro P. Rodriguez | | | | | 22e. ADDRESS
1708 W. Rogers Ave. Baltimore Md 21209 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lilly & Zeiler Inc. 1901 Eastern Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|-------------------------|---|---|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) James LEROY Sigley | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR FEB. 02 19 85 | | | | 2b. HOUR 7:23 P. | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR OCT. 9, 1984 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 3 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
FEB. 02 19 85 | 7d. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7f. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
CURTIS BAY | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4622 CURTIS AVE. 21226 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(UNKNOWN) | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LINDA SUE SIGLEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
218.06.9053 | | 17. INFORMANT (MOTHER) ADDRESS
LINDA S. SIGLEY SAME AS 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 2-3-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
FEB. 6, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE A.A. MD. | | |
| 24. FUNERAL DIRECTOR
NAME SINGLETON FUNERAL HOME ADDRESS GLEN BURNIE, MD | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Lelia Davidson-Randall</i> | | |

20% COTTON FIBER

WILFELD

DMC



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
HOWARD E. SIMPSON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 10 85 | | 2b. HOUR
10 ⁰⁰ P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 15, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chairman of the Board | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel D. Simpson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mathilda Madonna | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW I 705 12 1403 | | 17. INFORMANT ADDRESS
Howard Simpson, Balto., MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>UNKNOWN - AUTOPSY REQUESTED</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>20 MINUTES</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>HEMATURIA</u> | | | | | | |
| 19a. DATE OF OPERATION
<u>NONE</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/10</u> 19 <u>85</u> , to <u>2/10</u> 19 <u>85</u> , that (I) (the hospital) saw the deceased alive on <u>2/10</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we all) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>P. A. Albertsen</u> | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>2/10/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>PETER ALBERTSEN</u> | | 22e. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/14/85 | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elizabeth, New Jersey | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>W. Davidson Henderson</u> | | |

415 York Road, Balto., MD 21212
 Henry W. Jenkins & Son Co.
 Elizabeth, New Jersey



Yes WW I 706 1 1406 Howard Simpson, Balto., MD

Samuel D. Simpson Mathilda
 100 W. University Park, Balto., MD 21201

White Man, 18, 1908
 New Jersey
 100 W. University Park, Balto., MD 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04821

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANK SIMPSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-3-85 | | | 2b. HOUR
8:00 P_M | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 20 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11 W. 20th St. Apt. 17J 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lane Simpson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Kenrick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-03-0177 | | 17. INFORMANT
ADDRESS
Ruth E. Simpson 11 W. 20th St. Apt. 17J | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.
Sepsis, shock, Renal failure, multiple myeloma | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1:29 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
1-29 | | CITY OR TOWN
85 | | COUNTY
2-3 | |
| 21g. STATE
19 | | 21h. DATE OF DEATH
2-3-85 | | 21i. TIME OF DEATH
19 85 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29 , 19 85 , to 2-3 , 19 85 , that (I) (we) lost saw the deceased alive on 2-3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Bich T Duong | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
2/3/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BICH T DUONG | | | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN
Baltimore, | | COUNTY
Md. | |
| 24. FUNERAL DIRECTOR
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Davidson-Randell | | | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---------------------------------|---|--|--|--|---|---|--|
| FOR
1. STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT LEE SIMPSON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 3, 1985 | | | 2b. HOUR
1:30 A | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 17 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7b. HOUR
1:30 A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
NIA | | 17. INFORMANT
ADDRESS
Diane Mobley 418 N. Castle Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart & Renal Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pancreatic Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Liver metastasis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 minutes</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.
<u>Gravid Prolapsed Placenta, Malignant Ascites</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>12/29/85</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Pancreatic Cancer</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>85</u> , to <u>2/3</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/2</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>James A. H. V. M.D.</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/3/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James A. H. V.</u> | | | | 22e. ADDRESS
<u>Johns Hopkins Hospital, Baltimore, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

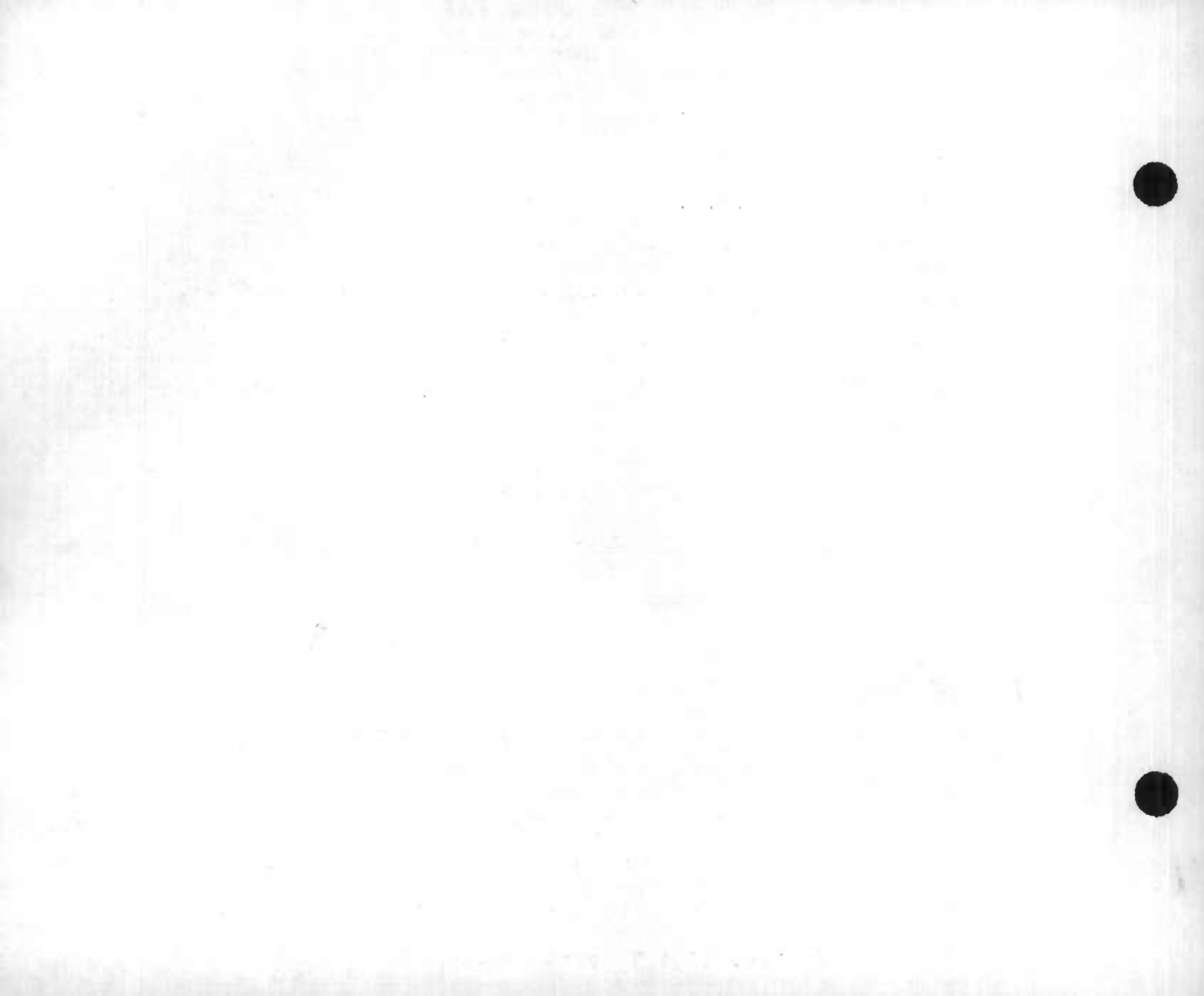
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|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ETHEL M. SIMS | | | 2a. DATE OF DEATH
MONTH 02 DAY 19 YEAR 85 | | 2b. HOUR
3:00 P M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH 9 DAY 20 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY BALTO | | | 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
5608 Gwynndale Ave. 21207 | | | | | |
| 14. FATHER'S NAME
FIRST Thurgood MIDDLE Blake LAST Blake | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Collins LAST Collins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
Doris M. Larkins 5608 Gwynndale Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF ARTERIO SCLEROTIC Cardiovascular Disease
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF diverticulitis of colon
(c) diverticulitis of colon | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET 2/17 CITY OR TOWN 85 COUNTY 2/19 STATE 85 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 19 85 , to 2/19 19 85 , that (I) (we) lost
saw the deceased alive on 2/19 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kuang-yen Huang MD | | DEGREE
MD | | 22c. DATE SIGNED
2/19/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG | | 22e. ADDRESS
Bon Secours Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | |
| 23d. LOCATION
Baltimore Co. | | 23e. STATE
Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Wm C March F/H Inc. ADDRESS 1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Pandell | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 2 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES Walter SINCLAIR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-20-1985 | | | 2b. HOUR
M | | | |
| 3. SEX
MALE | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 26 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2614 Loyola Northway | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Lobor | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2614 Loyola Northway | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES L. SINCLAIR | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA SINCLAIR | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
244-18-2463 | | 17. INFORMANT
ADDRESS
Gerdine SINCLAIR 2614 Loyola N.W. | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) probable myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

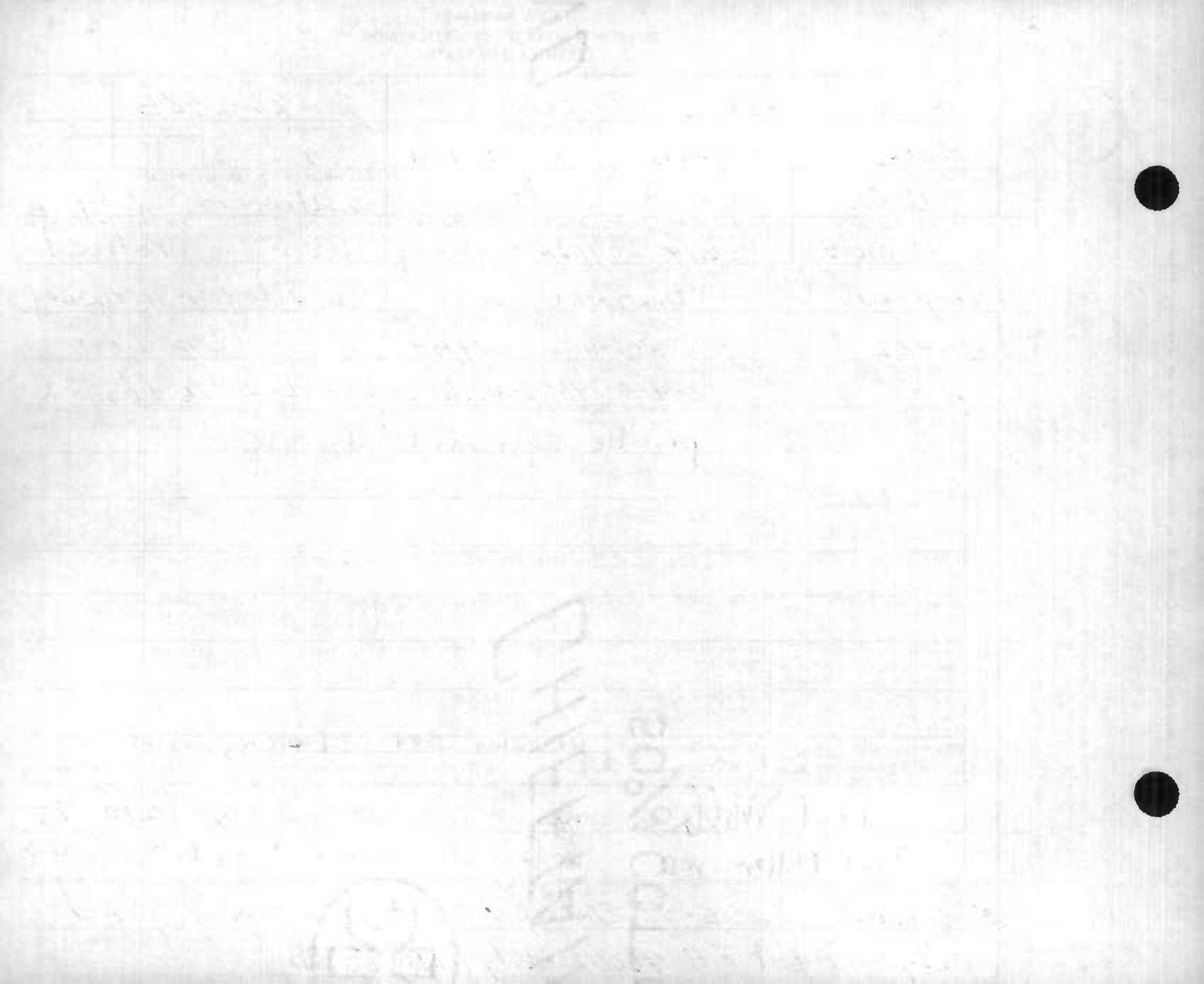
| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 19 84 to February 19 1985, that (I) (we) last saw the deceased alive on February 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Paul Miller MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Miller MD | | | | 22e. ADDRESS
201 E. University Parkway Balt. Md. 21217 | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
2-25-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett F.H. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | | |
| ADDRESS
4600 Liberty Rd | | | | 25b. REGISTRAR'S SIGNATURE
Gerdine Sinclair | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Glenn Elery Sipes</i> | | | 2a DATE OF DEATH MONTH DAY YEAR
<i>February 22, 1985</i> | | 2b HOUR
<i>9:59 A.M.</i> | | | | |
| 3 SEX
<i>Male</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR
<i>9 2 28</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
<i>56</i> | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>West Virginia</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10 CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)
<i>310 Honnel Street</i> | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired Clerk</i> | | 12b KIND OF BUSINESS OR INDUSTRY
<i>Soc. Secur. Adm.</i> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
<i>Maryland</i> | | | | 13b COUNTY
<i>Baltimore</i> | | 13c CITY OR TOWN
<i>Baltimore</i> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
<i>Sipes</i> | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Orpha Wright</i> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> IF YES GIVE BRANCH AND DATES)
<i>Yes U.W. 2</i> | | 16b SOCIAL SECURITY NO.
<i>217-26-7952</i> | | 17 INFORMANT ADDRESS
<i>Mary Agnes Sipes 310 Honnel Street 21224</i> | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>12</i> 19 <i>84</i> to <i>2/22</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2/22</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>(We) (I) did not view the body after death.</i> | | | | | | | | | |
| 22b SIGNATURE
<i>B. K. Yorkoff, M.D.</i> | | | | DEGREE
<i>M.D.</i> | | 22c DATE SIGNED
<i>2/25/85</i> | | 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<i>B. K. Yorkoff, M.D.</i> | |
| 22e ADDRESS
<i>7600 Osler Dr</i> | | | | 22f CITY OR TOWN
<i>Baltimore</i> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b DATE
<i>2-25-85</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Sacred Heart of Jesus</i> | | 23d LOCATION CITY OR TOWN COUNTY STATE
<i>Dundalk Balto. Co., Md.</i> | | | |
| 24 FUNERAL DIRECTOR (NAME)
<i>Charles S. Zeiler & Son Inc.</i> | | | | ADDRESS
<i>6224 Eastern Ave.</i> | | 25a DATE REC'D. BY REGISTRAR
<i>FEB 25 1985</i> | | 25b REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

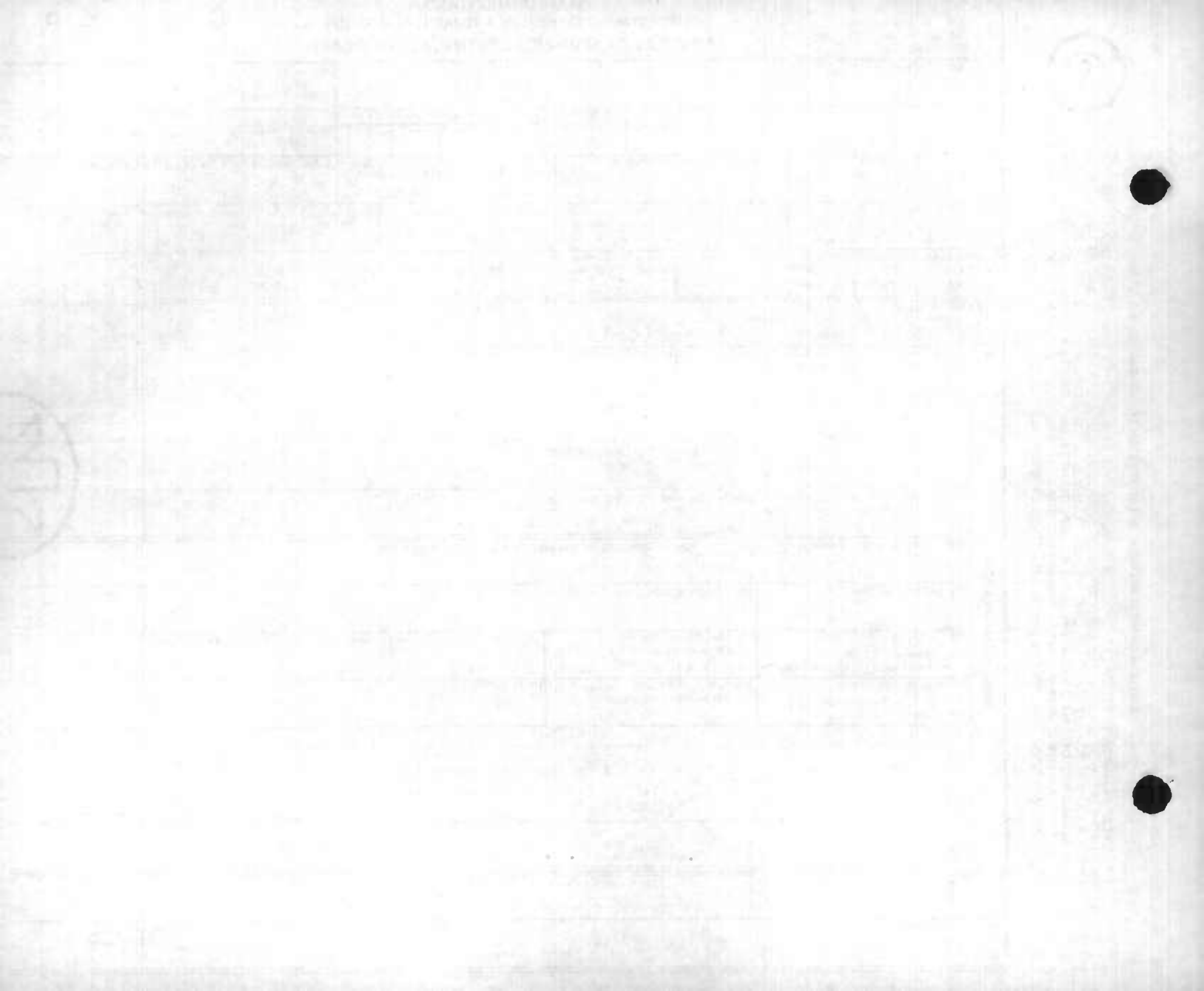
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|------------------|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
WALTER | | MIDDLE
(SILVERS) | | LAST
SIVELS | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2-18-85 19 | | 2b. HOUR
M
3:10A | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 10 26 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
58 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2-18-85 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2810 Hillsdale Ave. 21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Boston Sivels | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Jones | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
212-20-6402 | | 17. INFORMANT
ADDRESS
Boston Sivels, Jr. 2810 Hillsdale | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-18-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | | | ADDRESS
1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rendell</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 2 7

| | | | |
|--|--|---|--|
| 1- FOR STATE REGISTRAR <u>Clement</u> | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<u>Lt. Col. Clement G. Slattery</u> | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>2 21 85</u> | |
| 3 SEX
<u>Male</u> | | 2b. HOUR
<u>8⁰⁰ PM</u> | |
| 4 RACE
<u>Caucasian</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR
<u>88</u> 88 YRS | |
| 5. DATE OF BIRTH MONTH DAY YEAR
<u>2 28 96</u> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Westboro, Mass.</u> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<u>Balt. City</u> MD. | |
| 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Military-US AirForce (Ret.)</u> | |
| 10 CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Edgewood Usa Home</u> | | | |
| 13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>---</u> | |
| 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
<u>John W. Slattery</u> | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Harriette Norton</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>YES</u> | | 16b. SOCIAL SECURITY NO.
<u>115-10-6422</u> | |
| 17 INFORMANT ADDRESS
<u>Alice M. Slattery 310 Ridgemed Rd. Bal. Md.</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>19</u> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>Nov</u> 19 <u>84</u> , to <u>Feb</u> 19 <u>85</u> , that (b) (we) last saw the deceased alive on <u>Feb 21</u> 19 <u>85</u> , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Christine Hernandez MD</u> | | 22c. DATE SIGNED
<u>2-22-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Christine Hernandez</u> | | 22e. ADDRESS
<u>11722 Risterbrook Rd Risterbrook MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>Feb. 26, 1985</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat. Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Arlington, Arlington Co. Va.</u> | |
| 24 FUNERAL DIRECTOR NAME
<u>Mitchell-Wiedefeld Home</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 25 1985</u> | |
| ADDRESS
<u>6500 York Rd. Bal. Md. 21214</u> | | 25b. REGISTRAR'S SIGNATURE | |

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

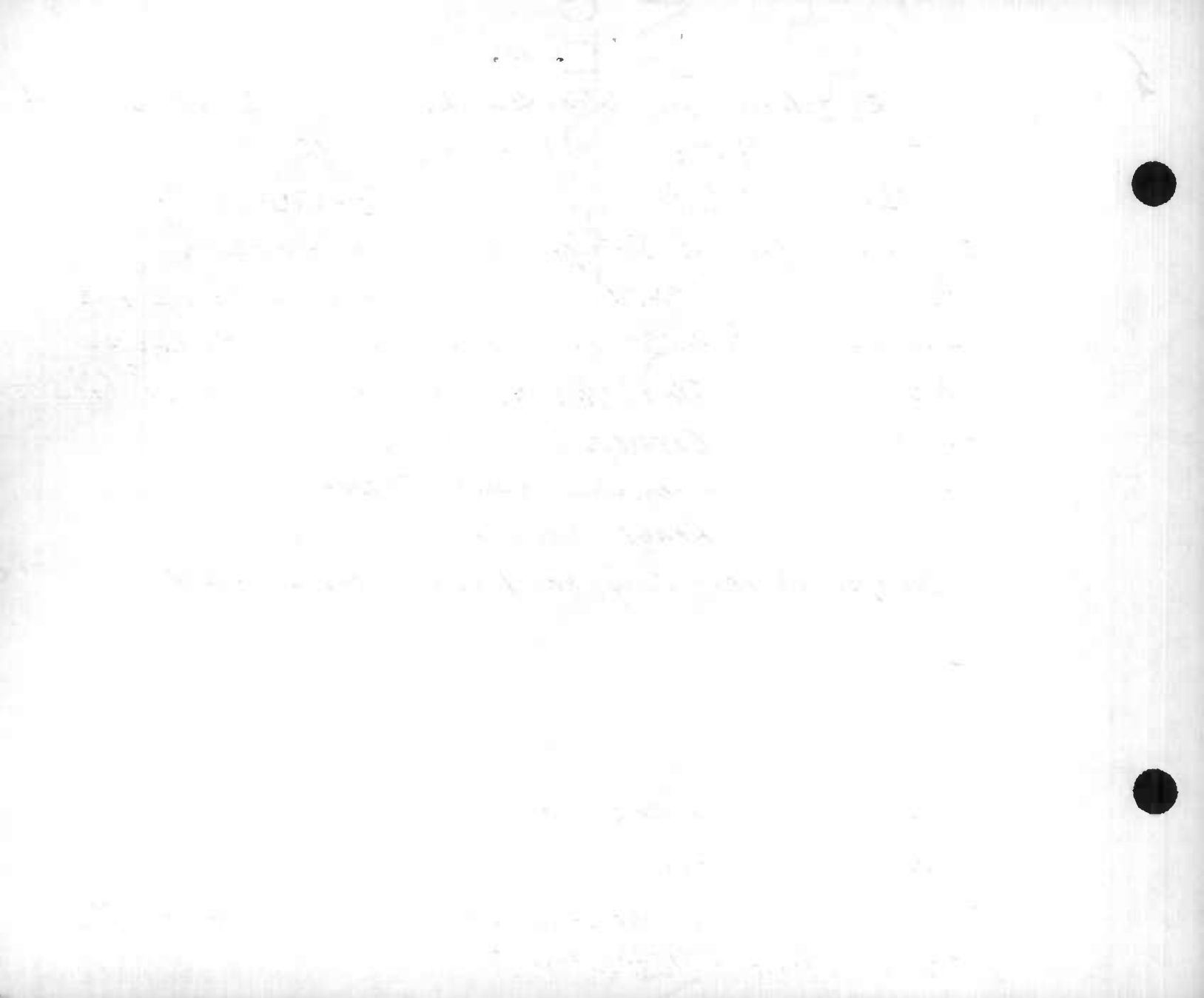
DHMH - 16 50M 4/83
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Elizabeth A. Slonkowski</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 27 85</i> | | 2b. HOUR
<i>10:35 AM</i> | |
| 3. SEX
<i>F</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>NOV. 9, 1902</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>MD.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTO. CITY</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTO.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>FRANCIS SCOTT KEY MED. CEN.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>BALTO.</i> | 13c. CITY OR TOWN
<i>BALTO.</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>59 N. LUZERNE AVE. 21205</i> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>GEORGE SCHMIDT SR.</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ANNABELLE BARLEGG</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>212-03-9727</i> | | 17. INFORMANT
ADDRESS
<i>HELEN A. BOGUCKI 32130 DONNELL ST. 21224</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Congestive Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Renal Failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Collapse of left lung, Endobronchial lesion & bleeding, pneumonia</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Charles W. Hoge</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>CHARLES W. HOGE M.D.</i> | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
<i>BURIAL</i> | | 23b. DATE
<i>3-2-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>OAKLAWN CEM.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTO. MD.</i> |
| 24. FUNERAL DIRECTOR
<i>HOFFMAN-SKARDA 3218 HUDSON ST.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 1 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) IDA E. SLOWIKOWSKI | | | 2a. DATE OF DEATH
MONTH 2 DAY 22 YEAR 85 | | 7b. HOUR
2:50 AM | |
| 3. SEX
Female | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 7 DAY 14 YEAR 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO CITY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Walter MIDDLE Kostalek LAST Bertha | | | 15. MOTHER'S MAIDEN NAME
FIRST Bertha MIDDLE Unknown LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-03-1654 | | 17. INFORMANT
Edward A. Slowikowski ADDRESS
815 Cedar Croft Rd. 21212 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION
DUE TO, OR AS A CONSEQUENCE OF (b) INTERNAL PERILOUS OBSTRUCTION
DUE TO, OR AS A CONSEQUENCE OF (c) SCHEUDERMAN | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
50 MIN.
2 WEEKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20 19 85 to 2/22 19 85 , that (I) (we) last saw the deceased alive on 2/22 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Jan Schreiber MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/22/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SCHREIBER | | 22e. ADDRESS
Good Samaritan Hospital BALTO, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 25, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | |

BP

104
St. Louis
Missouri
June 10, 1904
Dear Sir:
I have the pleasure to acknowledge the receipt of your letter of the 8th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Name]
[Title]

Very truly yours,
J. H. [Name]
[Title]
[Address]
[City, State, and Zip]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| FOR
1 - STATE
REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
VIOLA SMALL | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 12, 1985 | | | 2b. HOUR
3:15 PM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 5- 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Food Service | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS / ZIP CODE
512 Street Per St. 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Davis | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-22-10 | | 17. INFORMANT ADDRESS
Mrs. Fannie McCreedy 5503 B | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CRIPPLE ARREST | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 minutes |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) HEART FAILURE | | | | | | | | | 30 minute |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction | | | | | | | | | one week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
COPD, Multifocal Atrial Tachycardia | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that this hospital attended the deceased from 1/29 19 85 , to 2/12 19 85 , that (I) (we) last saw the deceased on 2/12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James E. Greenwald M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2/12/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. GREENWALD | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus MD | | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Callahan | | | | | | ADDRESS
2431 G Oliver St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ralph W. Smallwood, Jr. CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|-------|--|--------|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | | 2a DATE OF DEATH | | | |
| FIRST | | MIDDLE | | LAST | | DATE | MONTH | DAY | YEAR |
| RALPH | | M. | | SMALLWOOD | | 2 | 9 | 1985 | 3:55PM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | |
| MALE | | WHITE | | December 19, 1913 | | 71 YRS. | | 3:55PM | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | City MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | St. Agnes Hospital | | | | Freight Adjuster | | Railroad | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | | |
| Maryland | | Baltimore | | Catonsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 17 INFORMANT | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | |
| Ralph | | W. | | Smallwood, Sr. | | Ruth | | DeHuff | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | | | |
| No | | 216-03-1270 | | E. Severna Park MD. 21146
Robert Sherman - 420 Ben Oaks Dr. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Acute Injunctive wall MC.</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>9</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <i>J. Sue</i> | | | | | | 2-9-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| DR. J. SUE | | St. Agnes Hospital, Caton Ave., Balto. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE RECD. BY REGISTRAR | |
| Burial | | 2-11-1985 | | Parkwood Cemetery | | Baltimore | | FFR 11 1985 | |
| 23f. NAME | | 23g. ADDRESS | | 23h. CITY OR TOWN | | 23i. COUNTY | | 23j. STATE | |
| Heroy M. & Russell C. Witzke Funeral Homes P.A. | | 1630 Edmondson Ave., Catonsville, MD. 21228 | | Baltimore | | Maryland | | | |
| 23f. NAME | | 23g. ADDRESS | | 23h. CITY OR TOWN | | 23i. COUNTY | | 23j. STATE | |
| Heroy M. & Russell C. Witzke Funeral Homes P.A. | | 1630 Edmondson Ave., Catonsville, MD. 21228 | | Baltimore | | Maryland | | | |
| 23f. NAME | | 23g. ADDRESS | | 23h. CITY OR TOWN | | 23i. COUNTY | | 23j. STATE | |
| Heroy M. & Russell C. Witzke Funeral Homes P.A. | | 1630 Edmondson Ave., Catonsville, MD. 21228 | | Baltimore | | Maryland | | | |

20% COTTON



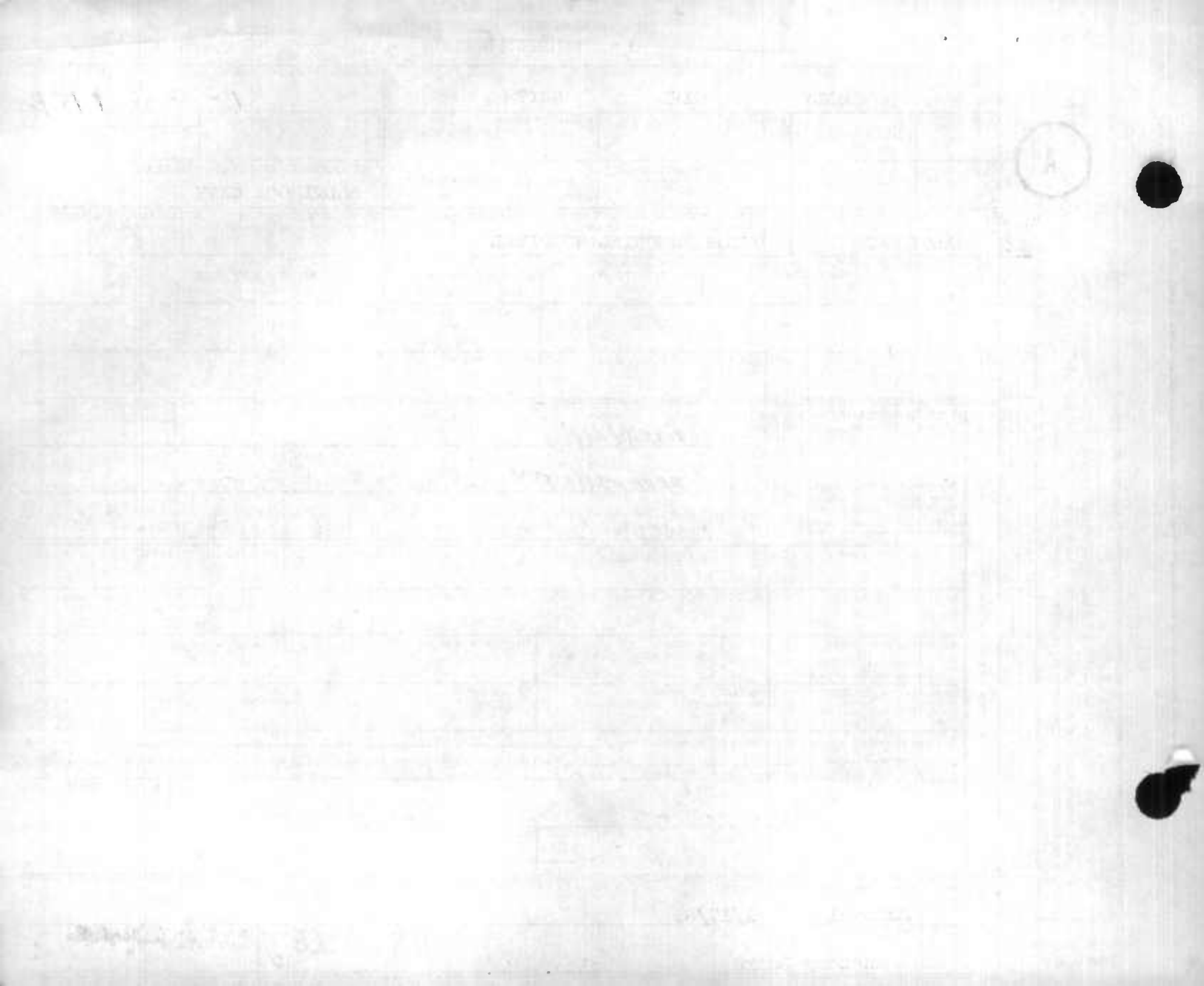
MADE IN
UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) | | FIRST
BABY | | MIDDLE
GIRL | | LAST
SMITH | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 15, 1985 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
YRS. 1-15-85 1:35 PM | | 7b. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Monkton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
17026 Gerting Road 00 000 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexius Dyer Smith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hope Rutledge Pearce | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
B.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASPHYXIA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>PREMATURITY 25w. B.wt. 765gm.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breech delivery (Vaginal)? Intrauterine bleeding</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>L. M. Monk</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FADIA MABROUK | | 22e. ADDRESS
UNION MEMORIAL Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
1/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25. DATE OF DEATH
JAN 20 1985 | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| (DOCK) DOC SMITH | | 2 13 85 | | 5:25A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | Black | MONTH DAY YEAR
9 7 19 | 65 YRS | BALTIMORE, CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| N. Carolina | U.S.A. | | BALTIMORE, CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | VAMC, BALTIMORE, MD. 21218 | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1727 Rutland Ave 21217 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | |
| George Smith | Annie Lindsay | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| YES | 244-18-5024 | Calvin Smith 1727 Rutland Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute uncalculitis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>1/26</u> , 19 <u>85</u> , to <u>2/13</u> , 19 <u>85</u> , that <u>XX</u> (we) last saw the deceased alive on <u>2/13</u> , 19 <u>85</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>XX</u> (we) (did) (<u>XXXX</u>) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| | | <u>Michael Durante MD</u> | | <u>2/13/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <u>MICHAEL DURANTE MD</u> | | 3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| BURIAL | 2/19/85 | Garrison Forest VA | Owings Mills, Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm C March F/H Inc. 1101 E North Ave. | | FEB 1 - 1985 | | <u>John Davidson</u> | |

10



NO. 1 MINUTE

RECEIVED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

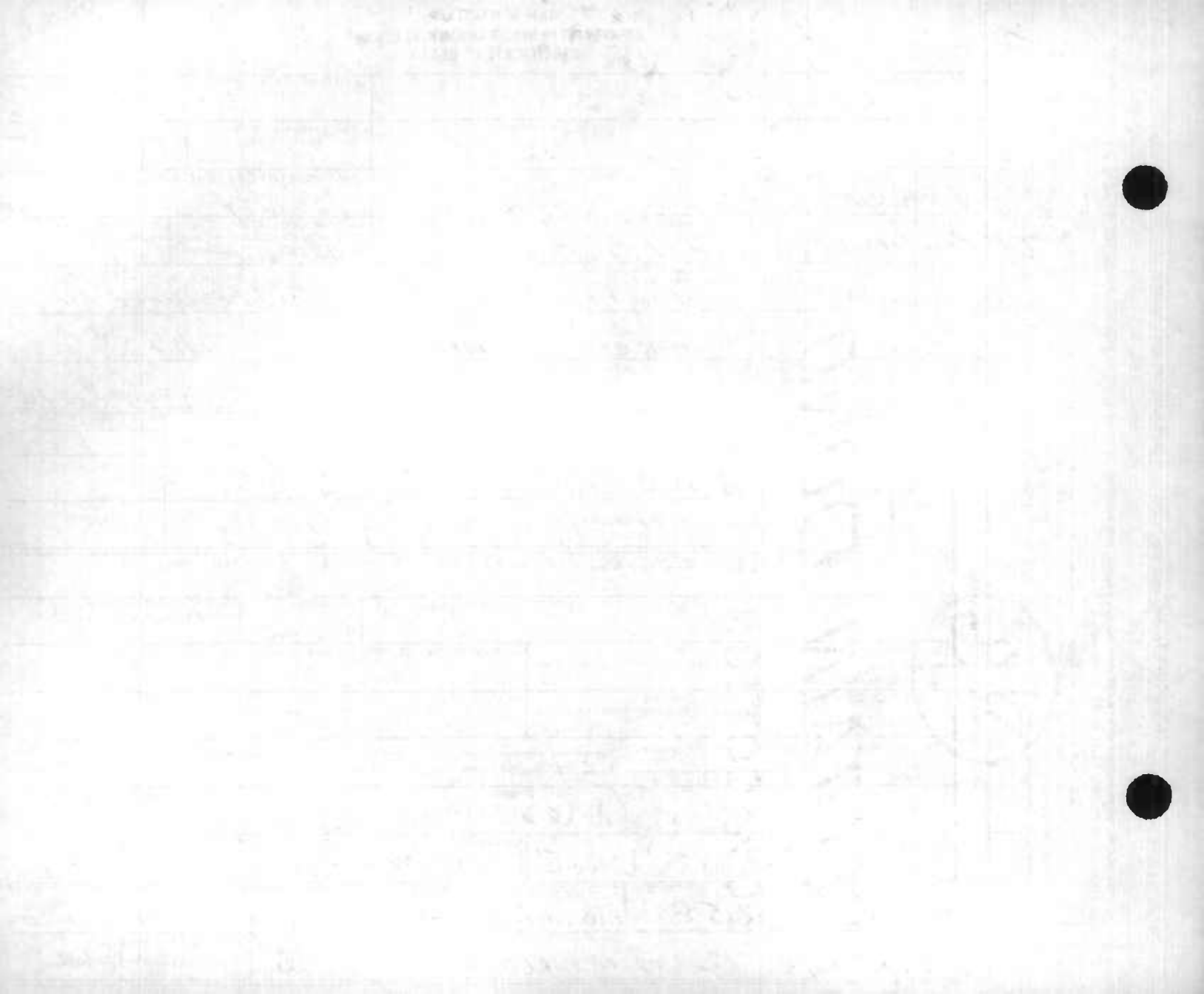
REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DOROTHY Smith | | | 2a. DATE OF DEATH
MONTH 2 DAY 1 YEAR 85 | | | 2b. HOUR
M | |
| 3. SEX
FEMALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 12 DAY 12 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
city MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1518 CHEASPEAKE AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
FAIRFIELD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
1518 CHEASPEAKE AVE | | 13f. STREET ADDRESS | | 13g. STREET ADDRESS | | 13h. STREET ADDRESS | |
| 14. FATHER'S NAME
FIRST RUBEN MIDDLE HARRIS LAST HARRIS | | 15. MOTHER'S MAIDEN NAME
FIRST AMELIA MIDDLE HILL LAST HILL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MARIENE THORNER | | ADDRESS
1518 CHEASPEAKE AVE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Apparent Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) with Chronic Angina Pectoris | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21h. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/23 19 84 to 10/24 19 84 , that (I) (we) lost
saw the deceased alive on 10/23 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
James Douglas Clarke | | DEGREE
M.D. | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22d. DATE SIGNED
2/4/85 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES DOUGLAS CLARKE | | 22f. ADDRESS
10524 Cedar Furnace Cir. Glen Burnie | | 22g. ADDRESS | | 22h. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2-5-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MD-NAT. MEM. PK. | | 23d. LOCATION
CITY OR TOWN LAUREL COUNTY MARYLAND STATE | |
| 24. FUNERAL DIRECTOR
NAME E.L. Phillips ADDRESS 1721 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | 25c. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



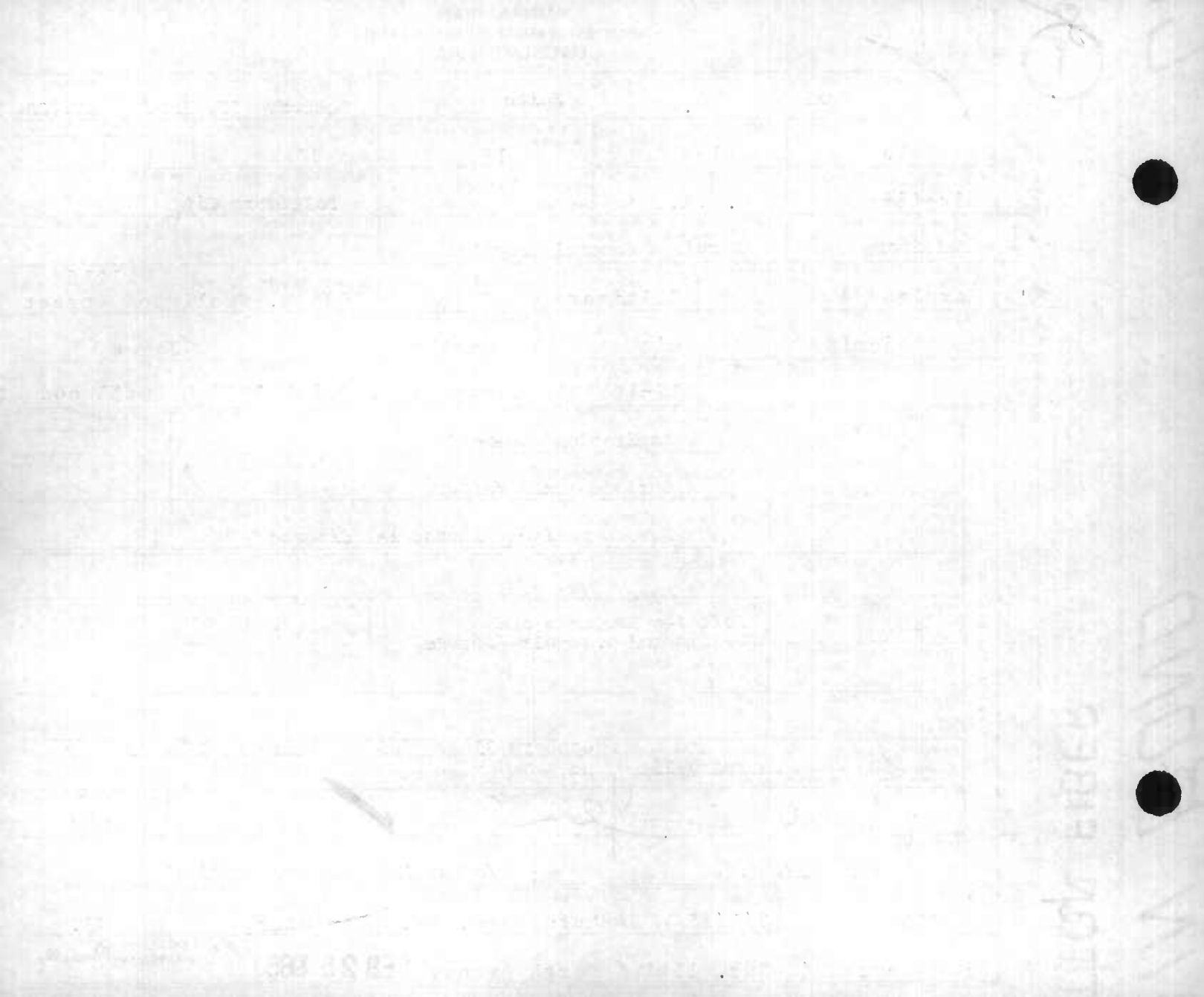
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is filled in, injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 04835 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Earl F. Smith | | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 25, 1985 | | 2b. HOUR
12:42AM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
7 19 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Benjamin Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Martha James | | 13e. STREET ADDRESS / ZIP CODE
21216 2006 N. Smallwood Street | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
217-16-4019 | | 17. INFORMANT ADDRESS
Gertrude V. Smith 2006 N Smallwood St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) Severe peripheral vascular disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Muocardial infarction | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION
2/12/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Left Leg Ischemia and Peripheral vascular disease | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from January 31 19 85 , to February 25 19 85 , that (X) (we) last saw the deceased alive on February 25 19 85 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Michael Yen</i> | | DEGREE
ATTENDING PHYSICIAN | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael YEN, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arbutus, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Erika Davidson-Randall</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top of page 3 and 4 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to the completion of the funeral.

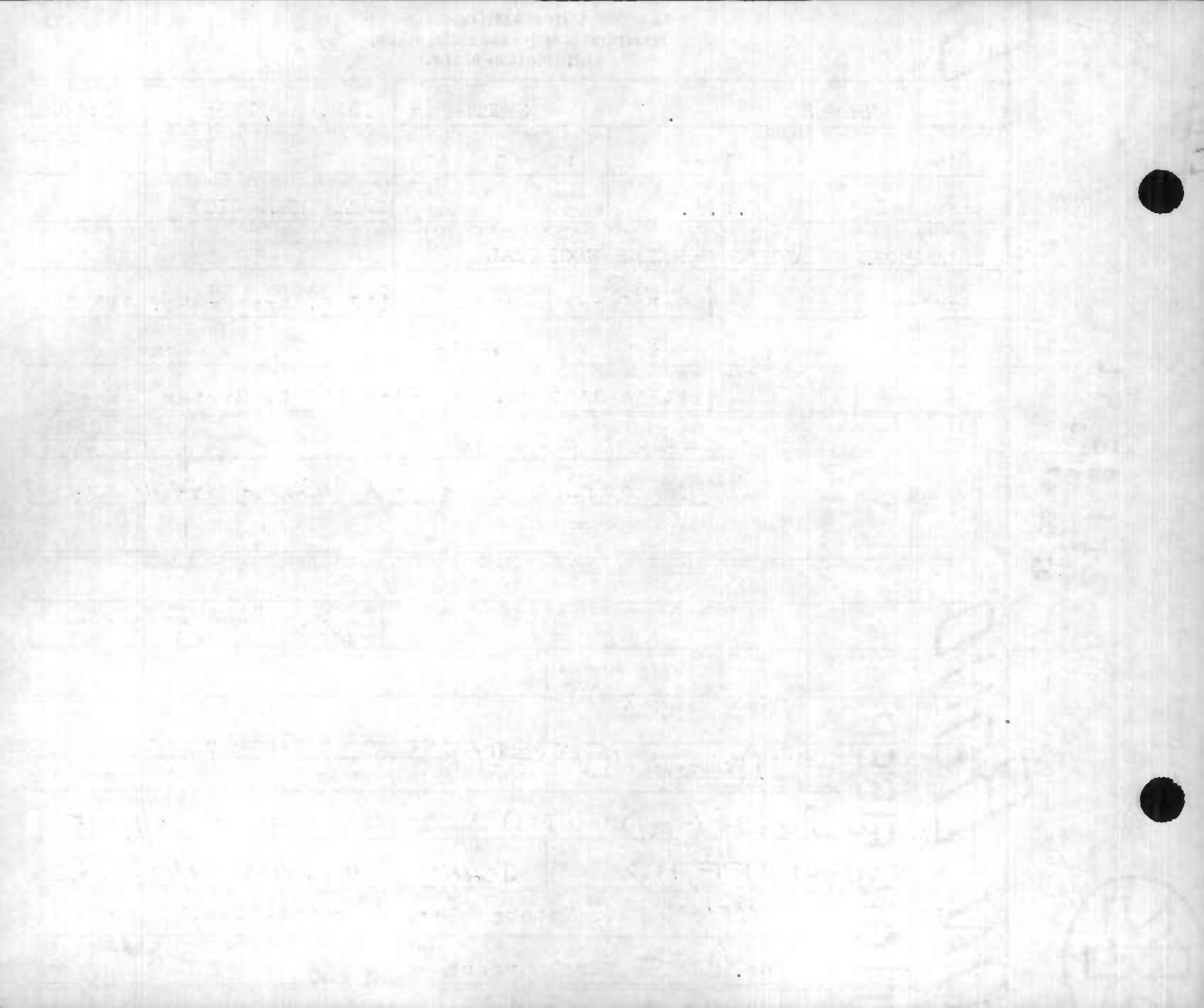
IMPORTANT: If item 21 is marked or item 18 shows any injury, or if a public event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES D. SMITH II | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 19, 1985 | | | 2b. HOUR
9:00AM | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 3 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
117 S. Exeter St. 21202 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James D. Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marcia Henry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-44-3107 | | 17. INFORMANT
ADDRESS
Marcia Smith 117 S. Exeter Street | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) IDIOPATHIC CONGESTIVE CARDIOMYOPATHY 7 years
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 February 19 85 to 19 February 19 85 , that (I) (we) last saw the deceased alive on 19 February 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
R. Roubenoff | | | | DEGREE
MD | | | | 22c. DATE SIGNED
2/19/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. ROUBENOFF, MD | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
Wm C March | | | | |



8 5 0 4 8 3 7

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>Manuel</i> | | MIDDLE
<i>Diaz</i> | | LAST
<i>Smith</i> | | 2a. DATE OF DEATH
MONTH
<i>2-7-</i> | | DAY
<i>85</i> | | YEAR
<i>8:15 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH
<i>May</i> DAY
<i>16,</i> YEAR
<i>1896</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>88</i> | | 7. IF UNDER 1 YEAR
MONTHS
<i>85</i> DAYS
<i>8:15 PM</i> | | 8. IF UNDER 24 HRS
HOURS
<i>85</i> MIN
<i>8:15 PM</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>California</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> | | 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Mechanic</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Mechanic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Automotive</i> | | 13a. STREET ADDRESS / ZIP CODE
<i>7004 Railway Avenue 21222</i> | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
<i>7004 Railway Avenue 21222</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Dundalk</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>7004 Railway Avenue 21222</i> | | 13f. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13g. STREET ADDRESS / ZIP CODE
<i>7004 Railway Avenue 21222</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>217-09-6760A</i> | | 17. INFORMANT
<i>Thomas J. Vain</i> | | 18. ADDRESS
<i>1814 E. Okaloosa Avenue</i> | | 19. ADDRESS
<i>Tampa, Florida 33604</i> | |
| 14. FATHER'S NAME
FIRST
<i>Unknown</i> | | 15. MOTHER'S MAIDEN NAME
FIRST
<i>Unknown</i> | | 16 | | | | | | | | | |

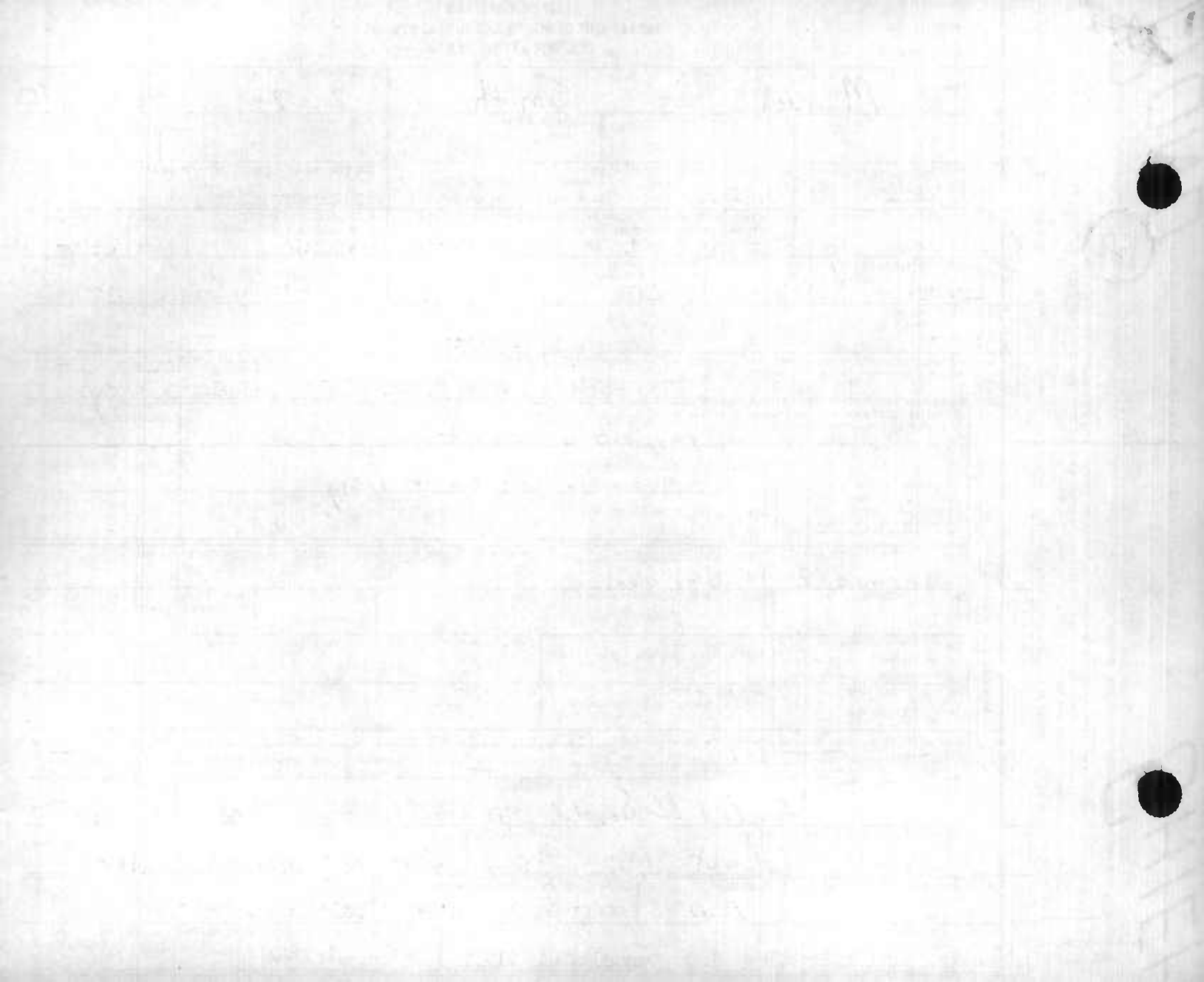
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please return it to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event,

MEDICAL CERTIFICATION

BP_____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|--|-------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mildred</i> | | | | | 2a. DATE OF DEATH MONTH <i>2</i> DAY <i>11</i> YEAR <i>85</i> | | 2b. HOUR <i>9:30</i> AM | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH <i>7</i> DAY <i>4</i> YEAR <i>195</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Crystal Bar</i> | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>504 S. Madiera St./21231</i> | |
| 14. FATHER'S NAME FIRST <i>Walter</i> MIDDLE LAST <i>Tilton</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Ellen</i> MIDDLE LAST <i>Gomez</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. <i>212-09-7360</i> | | 17. INFORMANT ADDRESS <i>Margaret Doty 2022 Armco Way 21222</i> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Influenza</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Vagina Cancer</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>SIP CVA</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> , 19 <i>84</i> , to <i>2/11</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2/11</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Debra S. Wertheimer MD</i> | | | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>2/12/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DEBRA S. WERTHEIMER</i> | | | | 22e. ADDRESS <i>5200 EASTERN AVE</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>2/15/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Oaklawn Cem.</i> | | 23d. LOCATION CITY OR TOWN <i>Baltimore</i> COUNTY <i>Md.</i> STATE | | | |
| 24. FUNERAL DIRECTOR NAME <i>Lilly & Zeiler Inc.</i> ADDRESS <i>1901 Eastern Ave.</i> | | | | 25a. DATE REC'D BY REGISTRAR <i>FEB 14 1985</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

BP

RECEIVED

20%

CHIEF

Police Dept. 100 Western Ave.

100 Western Ave.

100 Western Ave.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 3 9

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|--|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SHARON R SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 8, 1985 | | 2b. HOUR
9:30PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 3 63 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS. MONTHS DAYS
21 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |

| | | | | | |
|--|--|--|---|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE
Maryland Baltimore YES 3937 Frisby St. 21218 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas E. Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Vernell Peaks | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
217-80-5112 | | 17. INFORMANT
ADDRESS
Vernell Scott 3937 Frisby Street | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) A systole | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 hours |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Hypoxia | | 24 hours |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Adult Respiratory Syndrome | | 1 week |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Systemic Lupus Erythematosus**

| | | | |
|---|---|--|--|
| 19a. DATE OF OPERATION
1/2/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral and Aortic Valve Endocarditis | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22. I certify that (I) (this hospital) attended the deceased from **12/31**, 19 **84**, to **2/8**, 19 **85**, that (I) (we) last saw the deceased alive on **2/8**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|--|-----------------------------------|
| 22b. SIGNATURE
Samuel D. Lyons | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/8/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel D. Lyons | | 22e. ADDRESS
Johns Hopkins Hospital | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
2/13/85 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
|--|-----------------------------|---|--|

| | | | |
|--|-------------------------------------|---|---|
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | ADDRESS
1101 E North Ave. | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | 25b. REGISTRAR'S SIGNATURE
Julie Davidson-Randall |
|--|-------------------------------------|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon copies of this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate death certificate filed.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. These 300 carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, trauma, or traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOY YOLANDA SMITH | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 2, 1985 | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 27 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
5 | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
4816 OAKLAND PKWY AVE. 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BELL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PENNY SMITH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NONE | | 17. INFORMANT
ADDRESS
PENNY SMITH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Persistent Fetal Circulation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Meconium Aspiration.</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 minutes</u>
<u>4 days</u>
<u>5 days.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> 19 <u>85</u> , to <u>2-2</u> 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>February 2nd</u> 19 <u>85</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Paul Brewer MD</u> | | | | 22c. DATE SIGNED
<u>2/2/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Paul Brewer MD</u> | | | | 22e. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u>
<u>600 N. WALKER ST. BALTIMORE MD 21205</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
2/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS | |
| 24. FUNERAL DIRECTOR
JOHNS HOPKINS HOSPITAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 4 1

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
John STANLEY Smuck | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 4 85 | | | 2b. HOUR
10 ⁴⁵ AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 27 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. Ho. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR ARTS OR WORKING LIFE)
Machine Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Contracting | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Smuck | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Freesman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
217-19-5715 | | | 17. INFORMANT
Stella Smuck | | | ADDRESS
Balto Md 21225
6052 Ritchie Hwy | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Resp Arrest / Multiple
DUE TO, OR AS A CONSEQUENCE OF (b) Gastro-Intestinal Bleeding 28 days
DUE TO, OR AS A CONSEQUENCE OF (c) Duodenal Ulcer | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10/85 to 2/04/85, that (we) post
saw the deceased alive on 2/04/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Moss, MD | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/04/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Moss, MD | | | 22e. ADDRESS
2001 S. Hanover St. (SAGH) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto A.A. Md | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and the medical certificate must be completed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please return certificate, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | 8 5 0 4 8 4 2 | |
|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Adelaide A. Sneed | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 6 / 85 | | 2b. HOUR
6 05 A M | | |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 18 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Terry L Kidd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hester Not Known | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
578-26-8435 | | 17. INFORMANT
ADDRESS
Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pressure Sore
DUE TO, OR AS A CONSEQUENCE OF
(b) Dementia
DUE TO, OR AS A CONSEQUENCE OF
(c) CVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6 19 83 to 2/6 19 85 , that (I) (we) last saw the deceased alive on 2/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Debra S. Worthheimer MD | | | | 22c. DATE SIGNED
2/6/85 | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DEBRA S WORTHEIMER | | | | 22e. ADDRESS
5200 EASTERN AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/8/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
White Marsh Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--------------------------------------|-------------------------------|----------|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | | REG. NO. | | | |
| CHRISTIAN GETZ SNYDER | | 2/25/85 | | 6:00 AM | | 85 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MALE | WHITE | 12 15 01 | 83 YRS. | BALTIMORE CITY | | | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | U.S.A. | | BALTIMORE CITY | | | | | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | ST. AGNES HOSPITAL | STAT. ENGINEER | | GENERAL ELECTRIC | | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 17. STATE | 18. COUNTY | 19. CITY OR TOWN | 20. INSIDE CITY LIMITS? | 21. STREET ADDRESS / ZIP CODE | | | | |
| MARYLAND | BALTIMORE | LANSDOWNE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4374 HOLLINS FERRY ROAD, 21227 | | | | | |
| 22. FATHER'S NAME (FIRST MIDDLE LAST) | 23. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | 24. ADDRESS | | 25. DENTON, MD. | | | | | |
| CHARLES SNYDER | MADORA UNKNOWN | 101 S. 7th ST. | | 21629 | | | | | |
| 26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 27. SOCIAL SECURITY NO. | 28. INFORMANT | | 29. ADDRESS | | | | | |
| NO | 215-09-6821 | CHRISTIAN SNYDER | | 101 S. 7th ST. 21629 | | | | | |
| 30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia.</u> | | | | | | | | | |
| 31. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure.</u> | | | | | | | | | |
| 32. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure.</u> | | | | | | | | | |
| 33. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Renal failure.</u> | | | | | | | | | |
| 34. DATE OF OPERATION | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED | 36. AUTOPSY? | 37. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 38. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 39. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | |
| 41. INJURY OCCURRED | 42. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 43. LOCATION | | 44. CITY OR TOWN COUNTY STATE | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | ST. AGNES HOSPITAL | | | | | | | |
| 45. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> 19 <u>85</u> to <u>2/25</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/24</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 46. SIGNATURE | 47. DEGREE | 48. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 49. DATE SIGNED | | | | | |
| <u>J. Bonelli</u> | | | | <u>2/25/85</u> | | | | | |
| 50. PHYSICIAN'S NAME (TYPE OR PRINT) | 51. ADDRESS | 52. DATE REC'D. BY REGISTRAR | | | | | | | |
| <u>Bonelli</u> | <u>St. Agnes Hospital</u> | <u>FEB 26 1985</u> | | | | | | | |
| 53. BURIAL, CREMATION, REMOVAL (SPECIFY) | 54. DATE | 55. NAME OF CEMETERY OR CREMATORY | 56. LOCATION | 57. STATE | | | | | |
| BURIAL | 02-28-85 | MEADOWRIDGE MEM. PK. | ELKRIDGE | HOWARD MARYLAND | | | | | |
| 58. FUNERAL DIRECTOR | 59. ADDRESS | 60. REGISTRAR'S SIGNATURE | | 61. REGISTRAR'S SIGNATURE | | | | | |
| HUBBARD FUNERAL HOME, INC. | 4107 WILKENS AVE. | <u>J. Davidson-Bondare</u> | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FANNIE SOLARZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 85 | | | 2b. HOUR
8¹⁵ P.M. | | | |
| 3 SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 26 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11 SLADE AVE., APT. 905 (21208) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MAX DAGURT | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MOLLY SHEAR | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16a. SOCIAL SECURITY NO.
045-01-4611 | | | 17. INFORMANT
(92646)
MR SEYMOUR H. FRIEDMAN | | | ADDRESS
21792 STARFIRE LANE HUNTINGTON BEACH, CA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST; GI BLEED
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) COPD
DUE TO, OR AS A CONSEQUENCE OF
(c) GI BLEED
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 mins. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-13 , 19 85 , to 2-13 , 19 85 , that (I) (we) last saw the deceased alive on 2-13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
VE DALY | | | DEGREE
MO | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VE DALY | | | 22e. ADDRESS
SINAI HOSPITAL, BALTIMORE, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
2/15/85 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | | 25b. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Randall</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 4 8 4 5 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
LOUIS SOLOMON | | | | MONTH DAY YEAR
2/8/85 | | 7:40 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| MALE | | WHITE | | MONTH DAY YEAR
1/13/1916 | | 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | SINAL HOSPITAL | | GROCER | | FOOD | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| MD | | | | BALTIMORE | | APT 202
6605 BONNIERIDGE DR #21209 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
MORRIS SOLOMON | | | | FIRST MIDDLE LAST
MINNIE KRAUSE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| YES | | | | WWII ARMY 217-05-1418 | | MRS. FAYE SOLOMON
6605 BONNIE RIDGE DR. #21209 APT. 202 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFRACTION
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFRACTION
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
3 days | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5 1985, to 2/8 1985, that (I) (we) lost saw the deceased alive on 2/8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Kang Sun Lee | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/8/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KANG SUN LEG | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | 2-10-85 | | RUDOMER VEREIN | | ROSEDALE BALTO. MD | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 25. DATE RECEIVED BY REGISTRAR
FEB 19 1985 | | 26. REGISTRAR'S SIGNATURE
Davidson-Randall | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GRANVILLE L. SOPER | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 5 85 | | 2b. HOUR
4 ⁴⁵ AM | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
11 19 18 95 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Retired-Super-Post Office | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. CITY OR TOWN
Randallstown | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Soper | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Gibson | | 16. STREET ADDRESS / ZIP CODE
3525 Milford Mill Rd. 21207 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 218-42-9354 | | 17. INFORMANT
ADDRESS
Glen Rock, Pa.
Lorraine K. Slacum-Box 493, Rd. #1 17327 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Renal Failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5-10 min |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from 01/25, 19 85, to 02/05, 19 85, that (we) last saw the deceased alive on 02/04/85, 19 85, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
David G. Lange / 9260 | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David G. Lange | | 22e. ADDRESS
Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-8-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | ADDRESS
1050 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

22-1

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

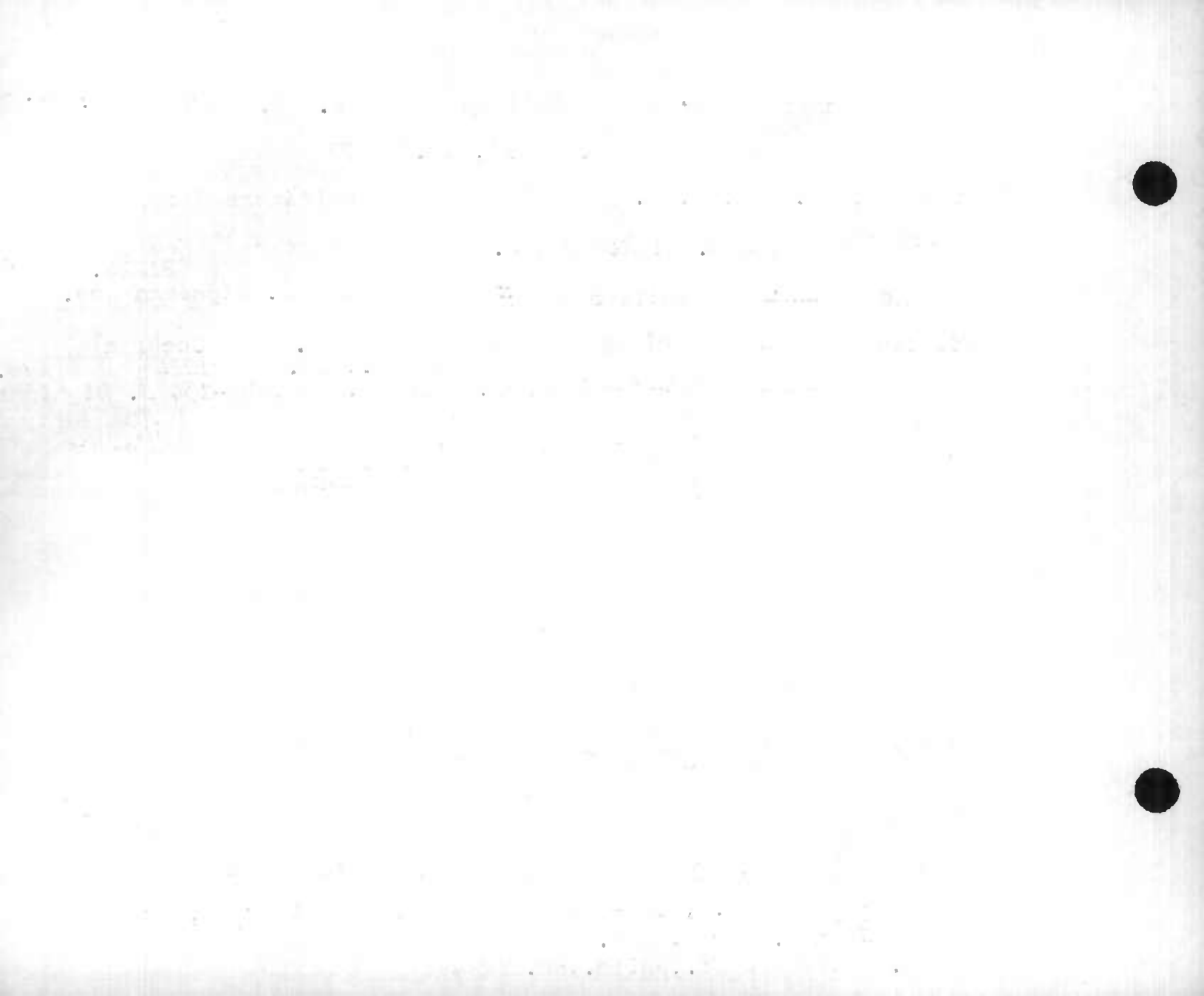
| | | | | | |
|---|---|---|---|--|---|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| Kenneth C. Soulsby | | Feb. 5, 1985 | | 6:30 A. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 72 | MONTHS DAYS HOURS MIN. | |
| June 14, 1912 | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore, Md. | U. S. A. | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 134 S. Highland Ave. | | Teamster | | Freight Hauler |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| Md | --- | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| William -- Soulsby | | Ida P. Cochran | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 213-09-4372 | | Balto., Md. ADDRESS 21224 Ave. | |
| | | | | Mrs. Hilda M. Soulsby-134 S. Highland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration, asphyxia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>bleeding esophageal lacer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>84</u> , to <u>2/5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Jan 5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>D.W. Mac Donald</u>
DEGREE <u>MD</u> | | 22c. DATE SIGNED
<u>2/5/85</u> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| D.W. MAC DONALD | | 9 S. HIGHLAND AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Feb. 7, 1985 | | Oak Lawn Cemetery | |
| | | | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | FEB 6 1985 | | <u>John A. Moran, Inc. Funeral Home</u> | |
| 3000 E. Baltimore St., Balto., Md. 21224 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504848

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
DAVID JACKSON SOWERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 1985 | | 2b. HOUR
P
9:30M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 11, 1948 | 6. AGE (IN YEARS LAST BIRTHDAY)
36 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wilm. Del. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembly Line | 12b. KIND OF BUSINESS OR INDUSTRY
Mobile Homes | |
| 13a. STATE
Md. | | | 13b. COUNTY
Cecil | 13c. CITY OR TOWN
Elkton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Geater A. Sowers | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Gooch | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
222-32-6785 | 17. INFORMANT
ADDRESS
Elkton, Md.
Suellen Sowers 2745 Blue Ball Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Brain Biopsy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Chronic Myelogenous Leukemia, Graft versus Host Disease.</u> | | | | | |
| 19a. DATE OF OPERATION
2/22/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Seizures | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5pm 2/25</u> , 19 <u>85</u> , to <u>930 PM 2/28</u> , 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>2/28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Eric Larsen</u> | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Eric Larsen | | 22e. ADDRESS
600 N. WOLFE ST. BALTO. MD.
Dept Pediatrics, Johns Hopkins | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3-4-85 | 23c. NAME OF CEMETERY OR CREMATORIUM
Immaculate Concept. | 23d. LOCATION
Cherry Hill County Cecil, Md. 21205 | | |
| 24. FUNERAL DIRECTOR
NAME
<u>John Doe</u> | | 25. DATE REC'D. BY REGISTRAR
MAR 06 1985 | | | |
| 25. REGISTRAR'S SIGNATURE
<u>John Doe</u> | | 26. REGISTRAR'S SIGNATURE
<u>John Doe</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John Spain | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/11/85 | | 2b. HOUR
11 PM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 4 29 | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1512 N. Broadway 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John W. Spain | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
220-02-8805 | | 17. INFORMANT
ADDRESS
Melody Hinton 1827 W. Fairmount Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Resp Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) 320815
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 min
48 hrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/11 , 19 85 , that (I) (we) lost the deceased alive on 2/11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
G. Ballweck | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Ballweck | | 22e. ADDRESS
FSICKC. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/14/85 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1985 | | 25b. REGISTRAR'S SIGNATURE
Wm March |

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20-11-5

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10-10-10

10-10-10

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10-10-10

10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 5 0

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Katina Trikeriotis SPANOS Spanos</i> | | | 2a. DATE OF DEATH
MONTH <i>2</i> DAY <i>6</i> YEAR <i>85</i> | | | 2b. HOUR
<i>1020 AM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH <i>1</i> DAY <i>17</i> YEAR <i>03</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Greece</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Housework</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
1. STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST <i>Michael</i> MIDDLE <i>Trikeriotis</i> LAST <i>Trikeriotis</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Michael</i> MIDDLE <i>Spanos</i> LAST <i>301 Honnel Street 21224</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>213-07-91540</i> | | 17. INFORMANT
ADDRESS
<i>Michael Spanos 301 Honnel Street 21224</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>BREAST CANCER</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/21/85</i> 19____, to <i>2/6/85</i> 19____, that (I) (we) last
saw the deceased alive on <i>2/6</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>John Davis MD</i> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JOHN DAVIS MD</i> | | | 22e. ADDRESS
<i>PSKMC BALD MD</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | | 23b. DATE
<i>2-9-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Eastwood, Balto. Co., Md.</i> | | |
| 24. FUNERAL DIRECTOR
NAME <i>Charles S. Zeiler & Son Inc.</i> ADDRESS <i>6224 Eastern Ave.</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 8 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | |

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James

Thompson

Smith

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Belmont

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Rufus L.C. Spence | | | 2a. DATE OF DEATH
MONTH 2 DAY 16 YEAR 85 | | | 2b. HOUR
9:35 PM | | | |
| 3. SEX
M | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH FEB. DAY 13 YEAR 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)
MERCY HOSPD. | | | | 12a. USUAL OCCUPATION
(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
BETH-STEEL | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1812 GLEN RIDGE RD. 21234 | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE F. LAST SPENCE | | | | 15. MOTHER'S MAIDEN NAME
FIRST ELIZA MIDDLE C. LAST LIDIARD | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WORK DATES) 105-10-9607 | | 17. INFORMANT
ADDRESS JOHN F. KETCHUM SAME-MS 13E. 21234 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia and septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
dehydration, cancer of the tongue, | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 85 , to 2/16 , 19 85 , that (I) (we) last saw the deceased alive on 2/16 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ever J. Selsky MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ever J. Selsky MD | | | | | | 22e. ADDRESS
Mercy Hospital
301 St. Paul St. Balto. Md 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
2-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CARMEL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | |
| 24. FUNERAL DIRECTOR
HOFFMAN-SKARDY 3218 HUDSON ST. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
P. A. Anderson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

BP

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 6032

1. The first part of the document discusses the importance of maintaining accurate records of all activities. It emphasizes that this is essential for ensuring the integrity and reliability of the data collected. The document also notes that this process is a continuous one, requiring regular updates and reviews.

2. The second part of the document describes the various methods used to collect and analyze data. It mentions that these methods are designed to be both efficient and effective, allowing for the rapid identification of trends and patterns. The document also highlights the importance of using appropriate statistical techniques to interpret the results of the analysis.

3. The third part of the document discusses the challenges associated with data collection and analysis. It notes that there are many factors that can affect the quality of the data, including human error, equipment malfunctions, and environmental conditions. The document also mentions that it is important to have a clear understanding of the limitations of the data and to be able to identify and address any potential biases.

4. The fourth part of the document discusses the importance of communication and collaboration in the data collection and analysis process. It notes that it is essential for all team members to be able to share information and ideas freely, and to work together to solve problems and make decisions. The document also mentions that it is important to have a clear understanding of the roles and responsibilities of each team member.

5. The fifth part of the document discusses the importance of documentation and record-keeping. It notes that it is essential to keep accurate records of all activities, including the data collection and analysis process. The document also mentions that it is important to have a clear understanding of the format and content of the records, and to be able to identify and address any potential issues.

6. The sixth part of the document discusses the importance of quality control and assurance. It notes that it is essential to have a clear understanding of the standards and requirements for the data collection and analysis process, and to be able to identify and address any potential issues. The document also mentions that it is important to have a clear understanding of the roles and responsibilities of each team member.

7. The seventh part of the document discusses the importance of training and education. It notes that it is essential for all team members to have the necessary skills and knowledge to perform their roles effectively. The document also mentions that it is important to have a clear understanding of the training and education requirements for each team member.

8. The eighth part of the document discusses the importance of ethics and integrity. It notes that it is essential for all team members to be able to identify and address any potential ethical issues, and to work together to ensure that the data collection and analysis process is conducted in a fair and honest manner. The document also mentions that it is important to have a clear understanding of the ethical requirements for each team member.

9. The ninth part of the document discusses the importance of security and confidentiality. It notes that it is essential to have a clear understanding of the security and confidentiality requirements for the data collection and analysis process, and to be able to identify and address any potential issues. The document also mentions that it is important to have a clear understanding of the roles and responsibilities of each team member.

10. The tenth part of the document discusses the importance of innovation and creativity. It notes that it is essential for all team members to be able to identify and address any potential issues, and to work together to develop new and innovative solutions. The document also mentions that it is important to have a clear understanding of the roles and responsibilities of each team member.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

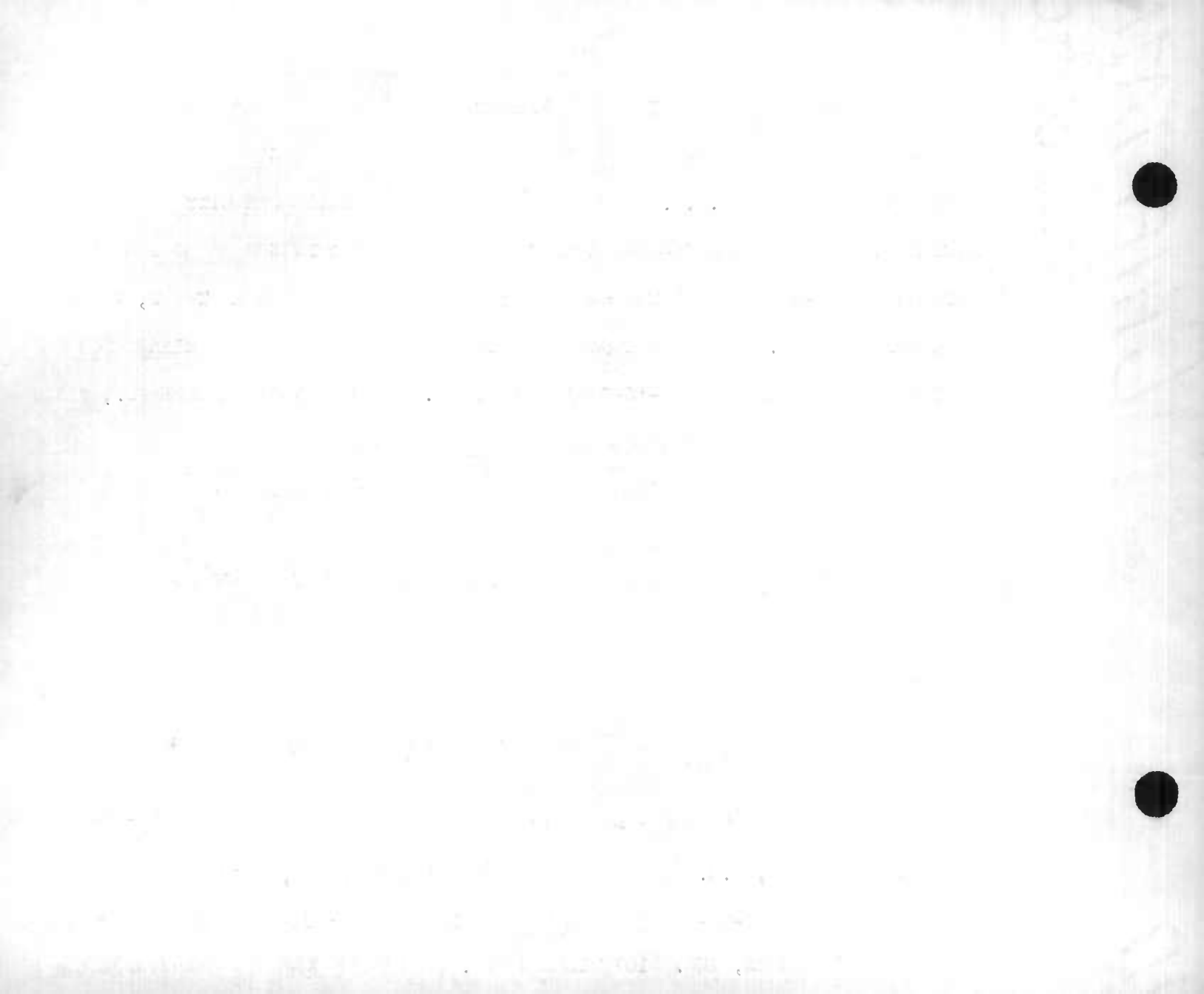
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 5 2

| FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CALVIN LEROY SPIEGEL | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 24 85 | | 2b. HOUR
1:20A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY
GAS & ELECTRIC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2020 WILHELM STREET, 21223 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS A. SPIEGEL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY EISENBAUCH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 217-16-7095 | | 17. INFORMANT ADDRESS
LOUISE L. SPIEGEL 2020 WILHELM ST., 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease (Hx post MI)
DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma post Sx + irradiation
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1974 to Feb 1985 , that (I) (we) lost
saw the deceased alive on 11/14 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, or (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Eugenio Benitez | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED
02-26-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENIO BENITEZ, M.D. | | | | 22e. ADDRESS
3455 WILKENS AVENUE, 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-28-85 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Lidia Davidson-Randall | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Samuel I. Spielman | | | 2a. DATE OF DEATH
MONTH 2 DAY 6 YEAR 85 | | | 2b. HOUR
7:20P M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 1 DAY 23 YEAR 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levindale | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ACCOUNTANT | | 12b. KIND OF BUSINESS OR INDUSTRY
ACCOUNTING | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
5615 PIMLICO RD. #21209 | | | |
| 14. FATHER'S NAME
FIRST LOUIS MIDDLE VICTOR LAST SPIELMAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST SARAH MIDDLE REIN LAST REIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
2B-10-1841 | | 17. INFORMANT MRS. ESTHER P. SPIELMAN
5615 PIMLICO RD. BALTO., MD 21209 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CA COLON with wide spread metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immed. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29 , 19 85 , to 2-6 , 19 85 , that (I) (we) last saw the deceased alive on 2-6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
2-7-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R-ZAW-WIN | | | | 22e. ADDRESS
Levindale GER. GR BALTO 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
FEB. 8, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
AITZ CHAM | | 23d. LOCATION
BALTIMORE COUNTY MARYLAND STATE | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE RECEIVED BY REGISTRAR FEB 13 1985
REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 5 4

| | | | | | |
|--|--|---|--|--|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| ROBERT G. SPURRIER | | Robert G. Spurrer | | 2 6 85 3:52 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| MALE | | WHITE | | 12 31 04 | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MARYLAND | | U.S.A. | | 80 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | South Baltimore General | | BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| MACHINE OPERATOR | | GLASS CORP. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | A.A. | | LINTHICUM | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13d. INSIDE CITY LIMITS? | |
| ANTHONY SPURRIER | | KATHERINE CREAMER | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 216-05-0908 | | 21239 | |
| | | GEORGE R. SPURRIER | | 6503 OLD ORCHARD ROAD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>85</u> , to <u>2/6</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2/6</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Henry E. Lyndon MD</u> | | 22c. DATE SIGNED
2/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Henry E. Lyndon | | 3001 S Hanover St | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 02-09-85 | | LOUDON PARK | |
| 24. FUNERAL DIRECTOR
NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| HUBBARD FUNERAL HOME, INC. | | 4107 WILKENS AVE. | | 25b. REGISTRAR'S SIGNATURE
<u>Gloria Davidson-Randall</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE SIGNED | | 23f. REGISTRAR'S SIGNATURE | |
| BALTIMORE CITY MARYLAND | | FEB 7 1985 | | <u>Gloria Davidson-Randall</u> | |



CHIEFLY



PO&C OCM HIF

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 5 5

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Magdalen</u> MIDDLE <u>M.</u> LAST <u>Staab</u>
<u>Magdalen M Staab</u> | | | 2a. DATE OF DEATH
MONTH <u>Feb</u> DAY <u>01</u> YEAR <u>1985</u> 2b. HOUR <u>4:30 P.M.</u> | |
| 3. SEX
<u>Female</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH <u>10</u> DAY <u>21</u> YEAR <u>1902</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>82</u> YRS. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Balto City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>MD</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>South Balto Gen Hosp.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Clerk Typist</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<u>U.S.F.G.</u> | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13b. STREET ADDRESS / ZIP CODE
<u>#9B Thunderbird Drive 20657</u> | | 14. FATHER'S NAME
FIRST <u>Alphonse</u> MIDDLE <u></u> LAST <u>Ruppert</u> | | |
| 15. MOTHER'S MAIDEN NAME
MIDDLE <u></u> LAST <u>Dietz</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | |
| 16b. SOCIAL SECURITY NO.
<u>215-07-8510</u> | | 17. INFORMANT
ADDRESS
<u>George Ruppert Same as 13e</u> | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) Pulmonary Edema, Renal + Hepatic Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Adult Respiratory Distress Syndrome

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pulmonary Embolism

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
<u>2/1/85</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u></u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>4:30 P.M. 2/1/85</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u></u> | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u></u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u></u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 26</u> , 19 <u>85</u> , to <u>Feb 1</u> , 19 <u>85</u> , that (I) (we) last
saw the deceased alive on <u>Feb 1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>M. E. Rodriguez</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>Feb 1, 1985</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Maria E. Rodriguez, MD</u> | | 22e. ADDRESS
<u>3801 S. Hanover St Balto MD 21230</u> | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>Burial</u> | | 23b. DATE
<u>2/5/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cem</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore === Md</u> | |
| 24. FUNERAL DIRECTOR
<u>George J. Gonce 4001 Ritchie Hwy Balto Md</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 4 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

BP

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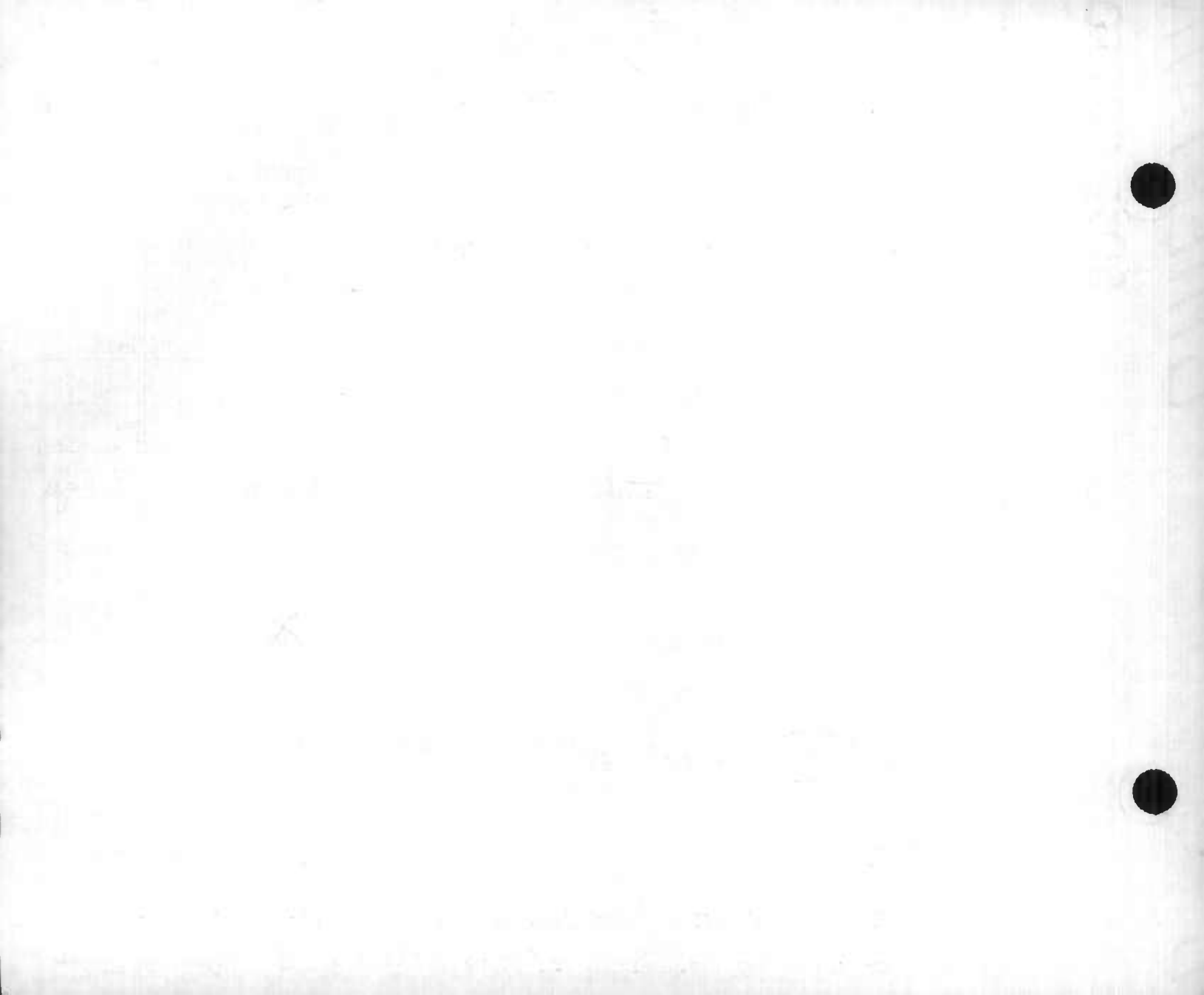
Handwritten notes and scribbles on lined paper, including a large circular stamp in the center and a smaller one in the top right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | |
|--|--|--|-------------------------------|---|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH (NMI) STAGG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 14 85 | | | | | 2b. HOUR
8:18 P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 20 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7. IF UNDER 24 HRS.
HOURS MIN.
0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
England | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6735 Oak Avenue 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Mc Farland | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Milburn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
217/54/1934 | | 17. INFORMANT
ADDRESS
Elizabeth E. Montague (same as 13e.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumococcal Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Influenza Respiratory Infection
DUE TO, OR AS A CONSEQUENCE OF (c) 7 days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Anemia | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 12 19 85 to FEB 14 19 85 , that (I) (we) last saw the deceased alive on Feb 14 19 85 , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22a. SIGNATURE
MD Soulen MD | | | | | | DEGREE
MD | | | 22b. DATE SIGNED
2-14-85 | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
SOULEN | | | | | | 22d. ADDRESS
FRANCIS SCOTT KEY MED CTR | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/18/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Randall | | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please place this certificate in the envelope. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504857

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT E. STANCIL | | | 2a DATE OF DEATH
MONTH DAY YEAR
February 17, 1985 | | 2b HOUR
9:45 | |
| 3 SEX
male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
12 22 18 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 72 HRS. HOURS MIN. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOPKINS | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | |
| 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
4524 Marble Hall Rd. 21239 | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Robert Stancil | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Snead | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
238-26-4536 | | 17 INFORMANT ADDRESS
Roosevelt Stancil 6220 Robinhill Rd. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF,
(b) Metabolic Acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Sepsis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
immediate
hours
weeks (2) | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes mellitus hepatic failure renal failure, seizures | | | | | | |
| 19a DATE OF OPERATION
2/5/85 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
large bowel obstruction | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
N/A | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | |
| 22a I certify that (1) this hospital attended the deceased from 1/28 19 85 , to 2/17 19 85 , that (1) we last saw the deceased alive on 2/17 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we did not view the body after death. | | | | | | |
| 22b SIGNATURE
Carla Marie Ford | | DEGREE
MD | | 22c DATE SIGNED
2/17/85 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Carla Marie Ford | | 22e ADDRESS
Johns Hopkins Hospital, Baltimore, MD | | | | |
| 23a BURIAL, CREMATION, REMOVAL
BURIAL | | 23b DATE
2/22/85 | | 23c NAME OF CEMETERY OR CREMATORY
Snead Grove Ch. Cem Ellerby, | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
N.C. | | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | | 25a DATE REC'D BY REGISTRAR
FEB 19 1985 | | | | |
| 25b REGISTRAR'S SIGNATURE
[Signature] | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES A. STANDIFORD | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 13, 1985 | | | | 2b. HOUR
6:30 PM | | | |
| 1a. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 23, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6507 Montrose Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Standiford | | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6507 Montrose Ave., 21212 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Upton R. Standiford | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mabel Kelly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218 23 3037 | | 17. INFORMANT
ADDRESS
Mrs. Betty V. Satndiford, Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of brain
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Spontaneous self carcinoma, lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mo
1 yr | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION
Dec. 1984 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Neck biopsy of lung tumor | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6100 York Road Balto., MD 21212 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1947 to Feb 13, 1985 , that (I) (we) last saw the deceased alive on Feb 12, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Frederick J. Vollmer MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-14-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Frederick J. Vollmer, MD | | | | 22e. ADDRESS
6100 York Road Balto., MD 21212 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE
Lia Davidson-Randall | | | |
| 4905 York Road Balto., MD 21212 | | | | | | | | | | | |

BP



CHAMBER OF COMMERCE

U.S. DEPARTMENT OF COMMERCE
WASHINGTON, D.C.

Executive Director
300 North Washington Ave., N.W.
Washington, D.C. 20001

Upton R. Starnford
Washington, D.C.

618-66-6007 Mrs. Betty V. Starnford

Mr. Frederick J. Volmer, MD 6100 York Road, Baltimore, MD 21211

Woolman
Woolman & Sons Co.
Baltimore, MD 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

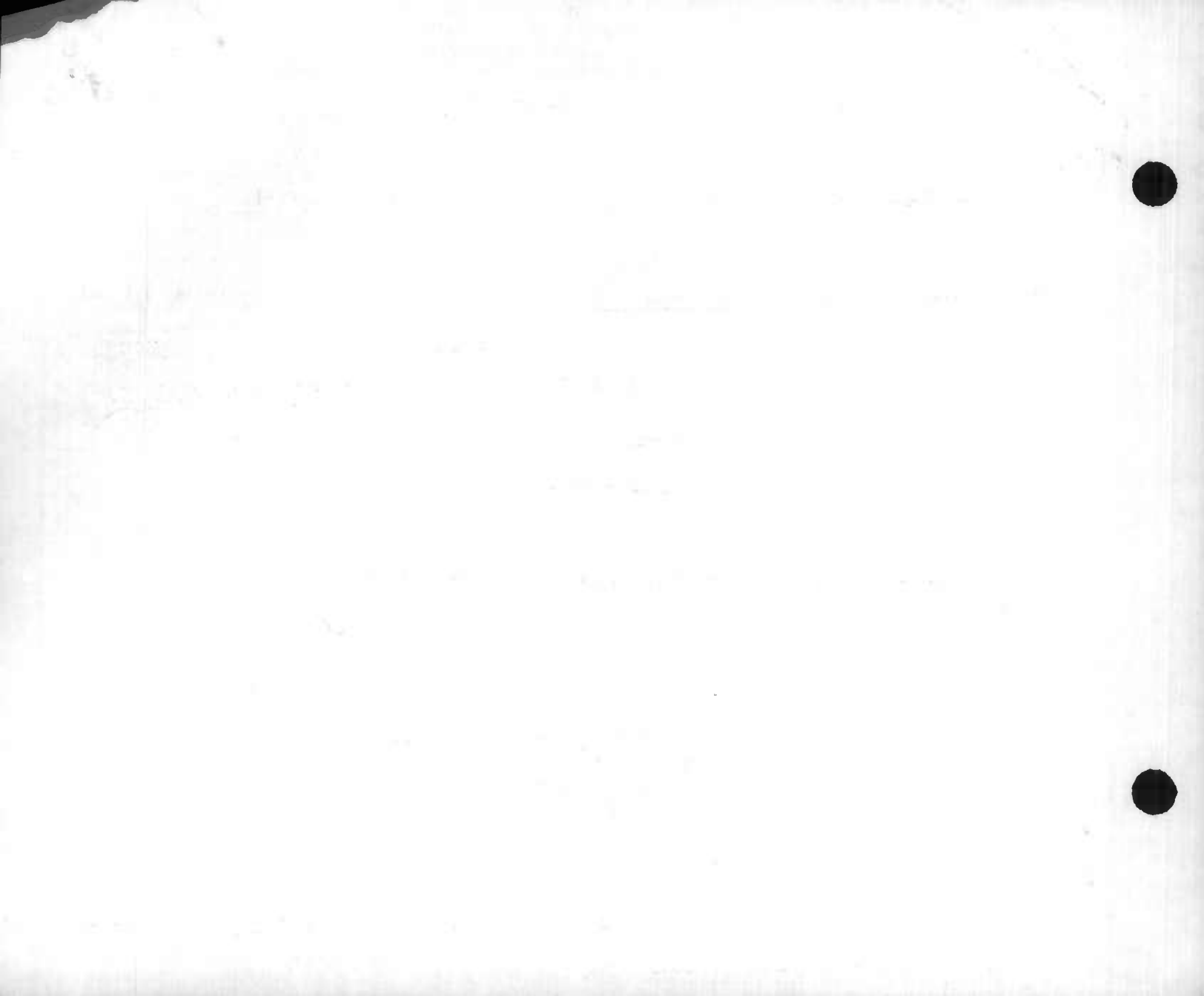
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 04859

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CATHERINE STANLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 9 85 | | 2b. HOUR
800 A.M. |
| 3. SEX
FEMALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR
5 24 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alverta Dyson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 18 6428 | | 17. INFORMANT
ADDRESS
Mary Willie 2845 Edgcomb Circle S. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Recent MI</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>HTN, Uibdm, A-fibrillation, CVA, CHF</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> 19 <u>85</u> , to <u>2-9</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-9</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
ROBERTA TABAKA DO | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-9-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERTA TABAKA DO | | 22e. ADDRESS
SINAI HOSP OF BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-14-85 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | |
| 24. FUNERAL DIRECTOR
NAME
The Bailey - Douglass Funeral Home | | 25. DATE REC'D. BY REGISTRAR (TYPE OR PRINT)
FEB 13 1985 | | | |



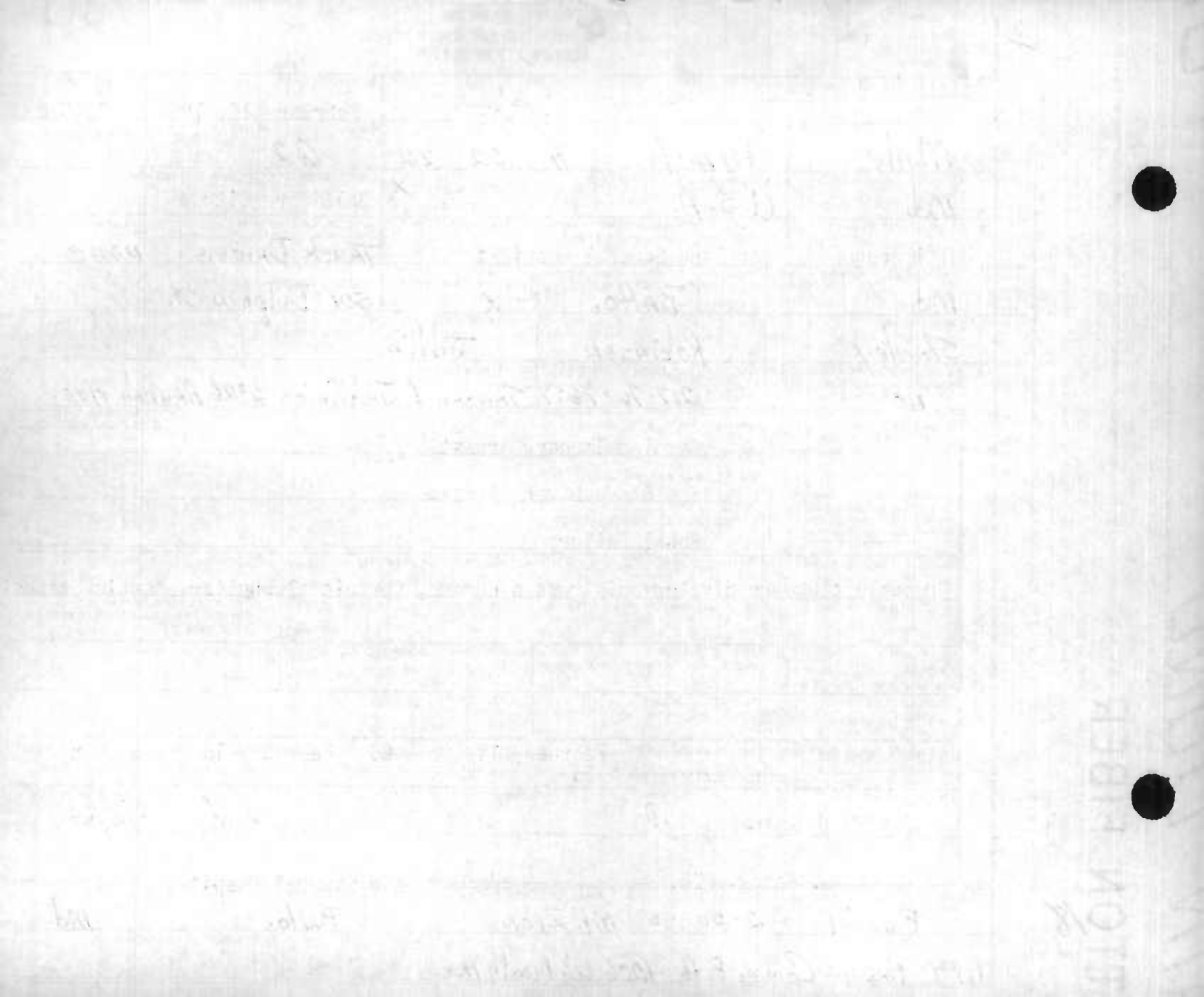
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a notice.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ernest Stanley | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 16, 1985 | | 2b. HOUR
7:30 a.m. | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 22 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
501 Dolphin St. 21217 | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Robinson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-76-9659 | | 17. INFORMANT ADDRESS
Sandra L. Jeffries 2326 Arunah Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>End Stage Liver Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Renal Failure</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Probable acute respiratory distress syndrome, Chronic alcoholism, Aortic Stenosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from February 14, 1985, to February 16, 1985, that (X) (we) lost
saw the deceased alive on February 16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (We) (I) (did not) view the body after death. X | | | | | | | |
| 22b. SIGNATURE
Thomas H. Ganey, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas H. Ganey, M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C. Brown Comm. F. H. 1206 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
John T. Anderson | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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3

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ARCHIE Mae Starks (STARKES) | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 4, 1985 | | | 2b. HOUR
11:04
M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 1 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1523 Mulliken Court 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hubert Barksdale | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Williams | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
Unknown | | | | | 16b. SOCIAL SECURITY NO.
215-16-5583 | | 17. INFORMANT ADDRESS
Sherman Barksdale 1523 Mulliken Ct. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) REASONS UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HOUR | |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7 , 19 85 , to FEB. 4 , 19 85 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John G. Sotos | | | | | DEGREE
— | | | 22c. DATE SIGNED
4 FEB 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John G. Sotos | | | | | 22e. ADDRESS
Johns Hopkins Hospital, Baltimore, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
2/9/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Calvary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | 25b. REGISTRAR'S SIGNATURE
— | | |

MEDICAL CERTIFICATION

29

20% COTTON FIBER

WINTER

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 6 2

| 1- FOR STATE REGISTRAR | | | REG. NO. | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LEROY B STATON | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 12 85 | | 2b. HOUR
12:55 AM |
| 3. SEX
Male | 4. RACE
Cau. | 5. DATE OF BIRTH MONTH DAY YEAR
3 18 22 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
V.A. Hosp. - Loch Raven | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bendix Radio | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nellie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W.II 213-12-2901 | | 17. INFORMANT ADDRESS
Mildred D. Staton 422 Meadow Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) RESTRICTIVE LUNG DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
?
YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 4, 19 85 to FEBRUARY 12, 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 12, 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Joyce B. Hark | | | | 22c. DATE SIGNED
2/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOYCE B. HARK | | | | 22e. ADDRESS
MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-15-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Park | |
| 24. FUNERAL DIRECTOR NAME
John C. Miller Inc. | | 24b. ADDRESS
6415 Belair Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Jane Anderson | | 25c. REGISTRAR'S TITLE
MD | | | |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

POPCOTON FIBERS

CON

11411

11411



MAY 24 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Ida B. Steibe | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 22 1985 | | | | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
10 29 1953 | | 6. AGE (IN YEARS LAST BIRTHDAY)
31 YRS. | | 2b. HOUR
M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
325 N. Robinson St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
325 N. Robinson St. 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Schlater | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nancy | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-62-1187 | | 17. INFORMANT ADDRESS
Charles Steibe 325 N. Robinson St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CANCER.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo
14 mos. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
EXTENSIVE BONY METASTASES | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Stephen A. Stahl | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN STAAL | | | | 22e. ADDRESS
JOHNS HOPKINS ONCOLOGY CTR. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
B. Dabrowski & Son 2818 E. Baltimore St. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
John Anderson-Randall | | | |

BP

32

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 6 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWARD JOHN STEINER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 85 | | | 2b. HOUR
9 30 AM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 8, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med. Center Engr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Balto County | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincent Steiner | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie unknown | | 16. SOCIAL SECURITY NO.
218-14-2636 | | | |
| 17. INFORMANT
Mary Stadler | | ADDRESS
5724 Onnen Rd, 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) sepsis / hypoxia
DUE TO, OR AS A CONSEQUENCE OF
(b) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Rule out Influenza superinfection
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
S/P CUA | | | | | | | |

MEDICAL CERTIFICATION

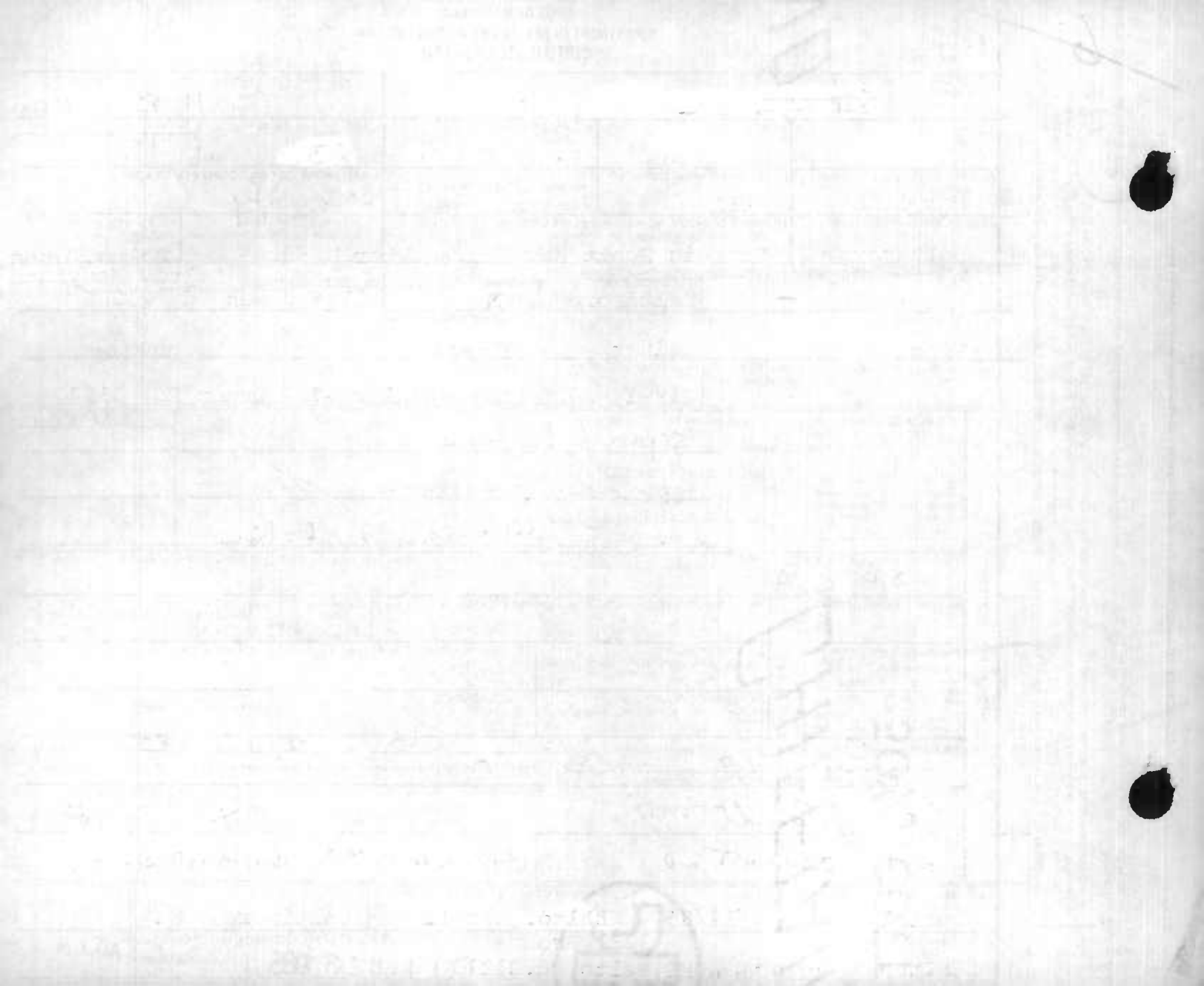
| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5 , 19 85 , to 2/11 , 19 85 , that (I) (we) lost
saw the deceased alive on 2/10 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Evan J. Samett MD | | | | DEGREE | | 22c. DATE SIGNED
2/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EVAN J. SAMETT, MD | | | | 22e. ADDRESS
4940 Eastern Ave, Baltimore MD 21224 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Bohemian Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, Balto, Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Gubia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
FRANCES STEPHEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/20/85 | | | 2b. HOUR
M | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 28 37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
St. Lucia | | 7b. CITIZEN OF WHAT COUNTRY?
BWI | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
4047 Annellen Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4047 Annellen Rd. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Hesley Stephen | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florina | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
214-64-2129 | | 17. INFORMANT ADDRESS
Margaret A. Patricia Stephen 4047 Annellen Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 19 85, to 2/20, 19 85, that (I) (we) last saw the deceased alive on 2/20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Joel Hammer, MD | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/21/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joel L. Hammer, M.D. | | | | | 22e. ADDRESS
6701 N. Charles St. Baltimore MD 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
J. Davidson | | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

3

UNITED STATES

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE
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WASHINGTON, D. C. 20535

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 6 6

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY Elizabeth STERLING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 8 85 | | | 2b. HOUR
MIN.
6 10 A M | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 8 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Operating Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1904 Mc Culloh St. N Baltimore, Md. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Allie Curry | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
213-26-5024 | | 17. INFORMANT ADDRESS
1904 Mc Culloh St. Baltimore, Maryland 21217 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 85 , to 2/8 , 19 85 , that (I) (we) lost
saw the deceased alive on 2/8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
W. ROYAL JR. | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. ROYAL JR., MD | | | 22e. ADDRESS
2600 Liberty Heights | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/13/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR'S NAME
Nutter & Sons | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | | 25b. REGISTRAR'S SIGNATURE
Susan Davidson-Randall | | | | |
| 26. FUNERAL HOME INC. BALTIMORE, MARYLAND 21216 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16 Per. F.H. 2/26/85JAB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

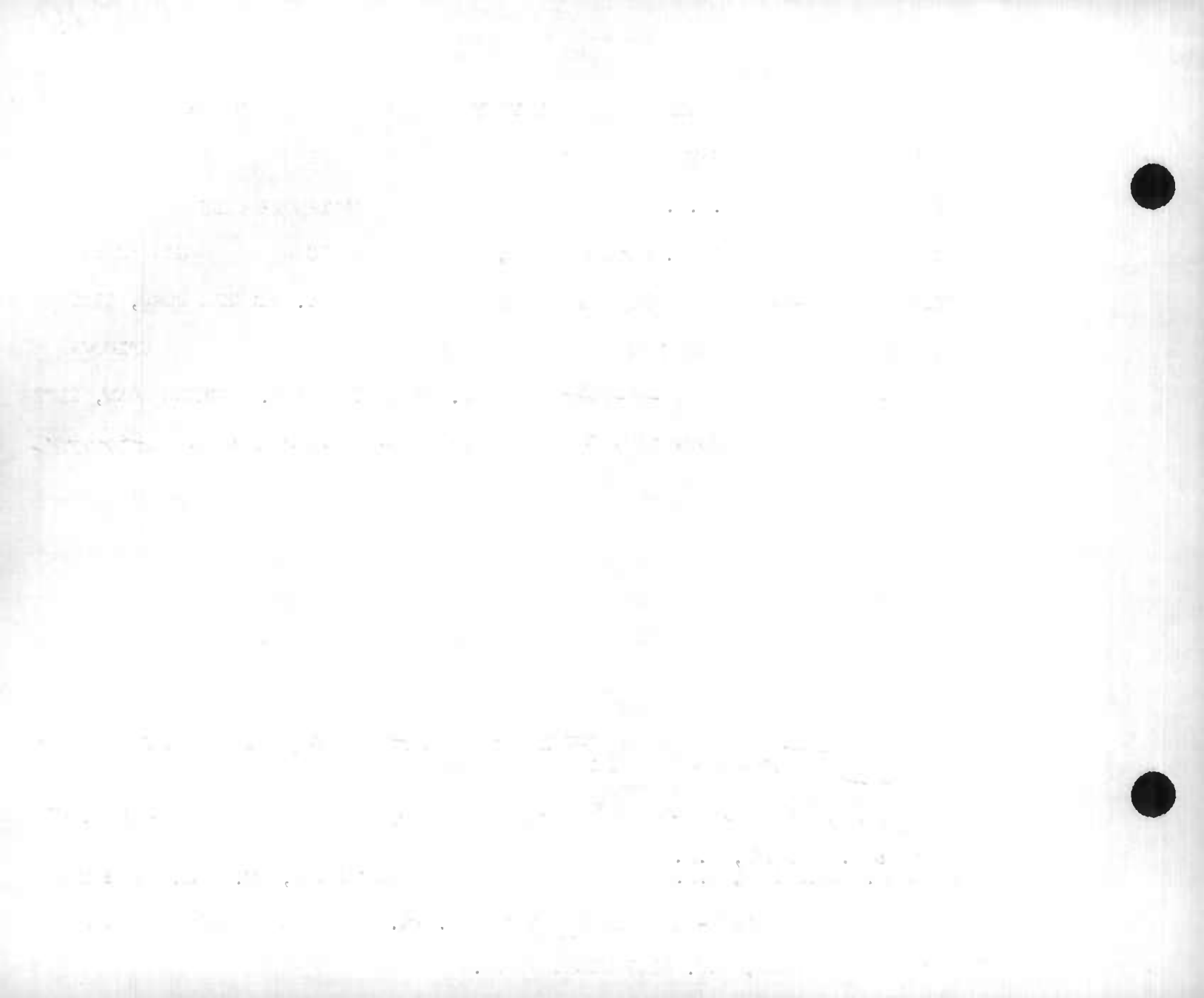
8 5 0 4 3 6 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RAYMOND BLAIN STETLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 23 85 | | | 2b. HOUR
M
AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 20 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
514 S. WICKHAM ROAD, 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | |
| 12b. KIND OF BUSINESS OR INDUSTRY
GAS STATION | | 13a. STATE
MARYLAND | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
514 S. WICKHAM ROAD, 21229 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE STETLEY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CECILIA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-01-1766 | | 17. INFORMANT
ADDRESS
LORA J. STETLEY 514 S. WICKHAM ROAD, 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic transitional cell carcinoma of bladder
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from FEB 15 , 19 85 , to FEB 23 , 19 85 , that (I) (we) lost
saw the deceased alive on FEB 20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Paul E. Gormley | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL E. GORMLEY, M.D. | | 22e. ADDRESS
ONCOLOGY DEPARTMENT, ST. AGNES HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELKCRIDGE HOWARD MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 6 8

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NORMA E. STEVENS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 85 | | | 2b. HOUR
955 M | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 08 16 | | 6 AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
ARBUTUS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1224 GREYSTONE ROAD, 21227 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN TEUFEL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MABEL GRAY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-09-8232 | | 17. INFORMANT
ADDRESS
ROLAND R. STEVENS 1224 GREYSTONE RD., 21227 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic subcutaneous carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>4 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>4 yrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>---</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>85</u> to <u>2/21</u> 19 <u>85</u> , that (I) (we) lost sight of the deceased alive on <u>2/21</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) (they) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>William B Davidson</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/21/85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>William B Davidson</u> | | | 22e. ADDRESS
<u>Mercy Hospital</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
02-22-84 | | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | ADDRESS
4107 WILKENS AVE. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

MEDICAL CERTIFICATION

NOT RECORDED
JAN 10 1902

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 3 6 9

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLARA W. STEVENSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 9 85 | | 2b. HOUR
6¹⁰ P.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
3 6 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MASON F. LORD | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | 12b. KIND OF BUSINESS OR INDUSTRY
Medical |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2935 Liberty Parkway 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Woodruff | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Molly Sauerwein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-22-7885 | | 17. INFORMANT
ADDRESS
20 Treeway Apt. 1A
Patricia A. Coleman Balto., MD 21204 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ACUTE M.I.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **ISCHEMIC HEART DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

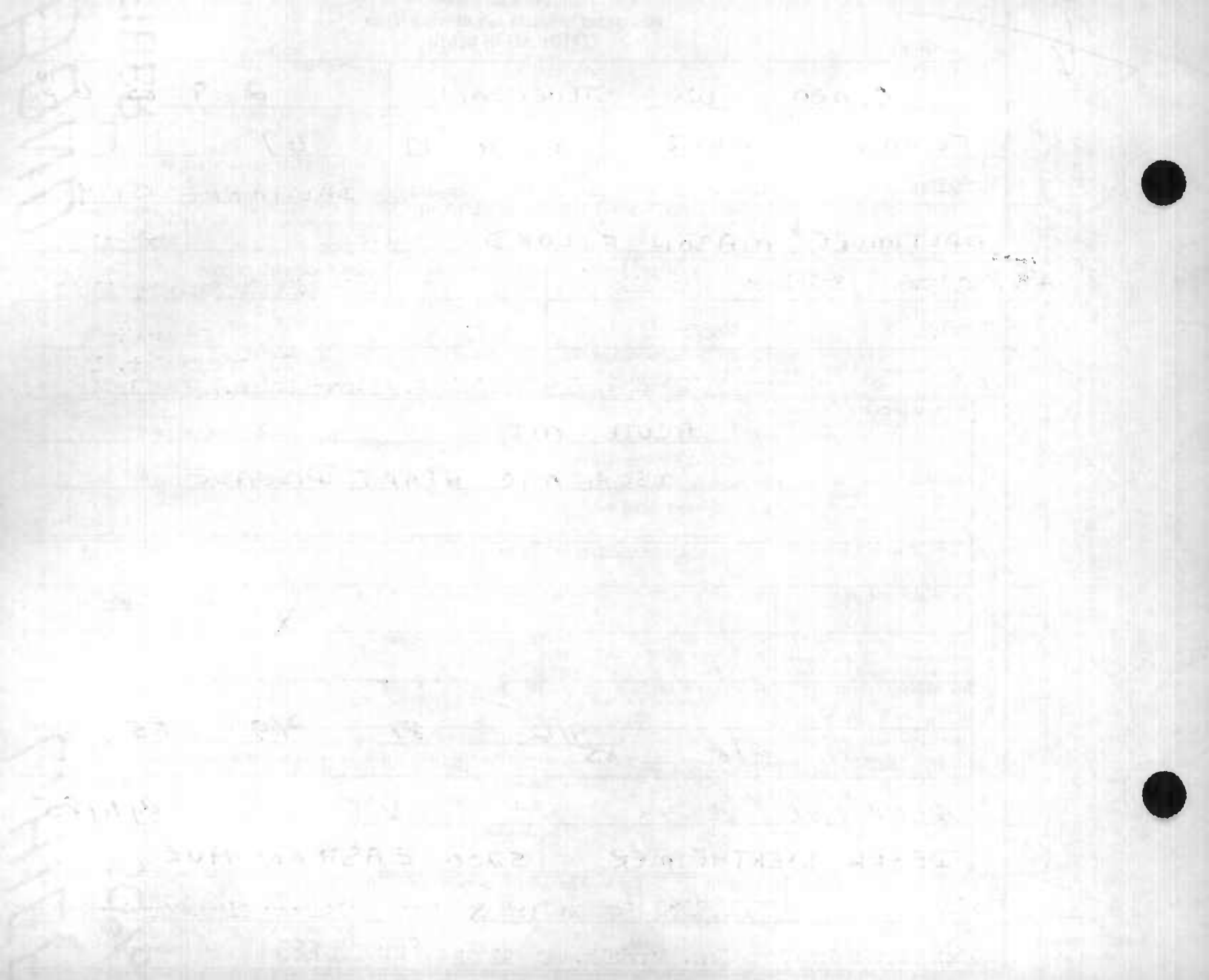
| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12 , 19 81 , to 2/9 , 19 85 , that (I) (we) lost
saw the deceased alive on 2/8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Debra Wertheimer</i> | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
2/11/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DEBRA WERTHEIMER | | 22e. ADDRESS
5200 EASTERN AVE. | |

| | | | |
|--|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
02/12/1985 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley, Inc. Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 13 1985 <i>Debra Davidson-Randall</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 7 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Pauline T. Steward | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 22, 1985 | | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 31, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(# NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1703 Belt St. Balto. Md. 21230 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
January, Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.F. & G | |
| 13a. USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1711 Belt St. Balto. Md. 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John C. Trust | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen L. Yeager | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
212-03-6599 | | 17. INFORMANT
ADDRESS
Mrs. John E. Trust, 3rd. 1004 Fallscroft Way, 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure, infection
DUE TO, OR AS A CONSEQUENCE OF (b) Obstruction
DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Ca of ovary
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(# EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 21g. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
James H. Dorsey, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-25-85 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS
6701 N. Charles St. Balto. Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 25, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCurly Funeral Home, 130 E. Fort Ave. Balto. Md. 21230 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

James H. Thompson
Commercial Corp of Oregon

James H. Thompson

James H. Thompson

10-14-1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/cremation permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|---|---|--|---|--|--|---------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD V. STOVER SR. | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-14-85 | | | 2b. HOUR
230A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 03 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
79 | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CZECHOSLOVAKIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. James Hospital 900 Caton Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RADIO ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
RADIO STATION | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
HALETHORPE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1805 WOODSIDE AVENUE, 21227 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAN PICZONSKI | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIA FRIDEL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-09-2748 | | 17. INFORMANT ADDRESS
MECHANICSVILLE, VA
EDWARD V. STOVER, JR. 2107 PEMBRIDGE DRIVE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent carcinoma of Larynx
DUE TO, OR AS A CONSEQUENCE OF (c) with metastases to Lungs and liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR (A.M.) MONTH DAY YEAR
340 P.M. 02/14/1985 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/1985 to 02/14/1985 , that (I) (we) lost saw the deceased alive on 02/14/1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Kurt N. Tull, MD | | | | | | DEGREE | | 22c. DATE SIGNED
02.14.85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KURT N. TULL, MD | | | | | | 22e. ADDRESS
ST. JAMES HOSPITAL
BALTO, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
02-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY CROSS CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BROOKLYN PK. A.A. MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE
Kurt N. Tull | |

MEDICAL CERTIFICATION

Page

28-44-2

08

THE VA. BOARD OF 1901

RECEIVED

EXHIBIT

THE VA. BOARD OF 1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 7 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|------------------------------------|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Baby Boy Strickland | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 15 '85 | | | 2b. HOUR 12¹⁰ AM | | | | |
| 3. SEX m | | 4. RACE N 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 2 4 195 | | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 25 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. | | 7b. CITIZEN OF WHAT COUNTRY? usa | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant | | 12b. KIND OF BUSINESS OR INDUSTRY - | | |
| 13a. STATE md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1011 Lendenhall St | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Manuella Strickland | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Severe Prematurity**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Zamoria | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|--|--|--------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 2/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE RECD. BY REGISTRAR FEB 25 1985 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Jane Davidson-Rondelle | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PREMIUM

20% COTTON F



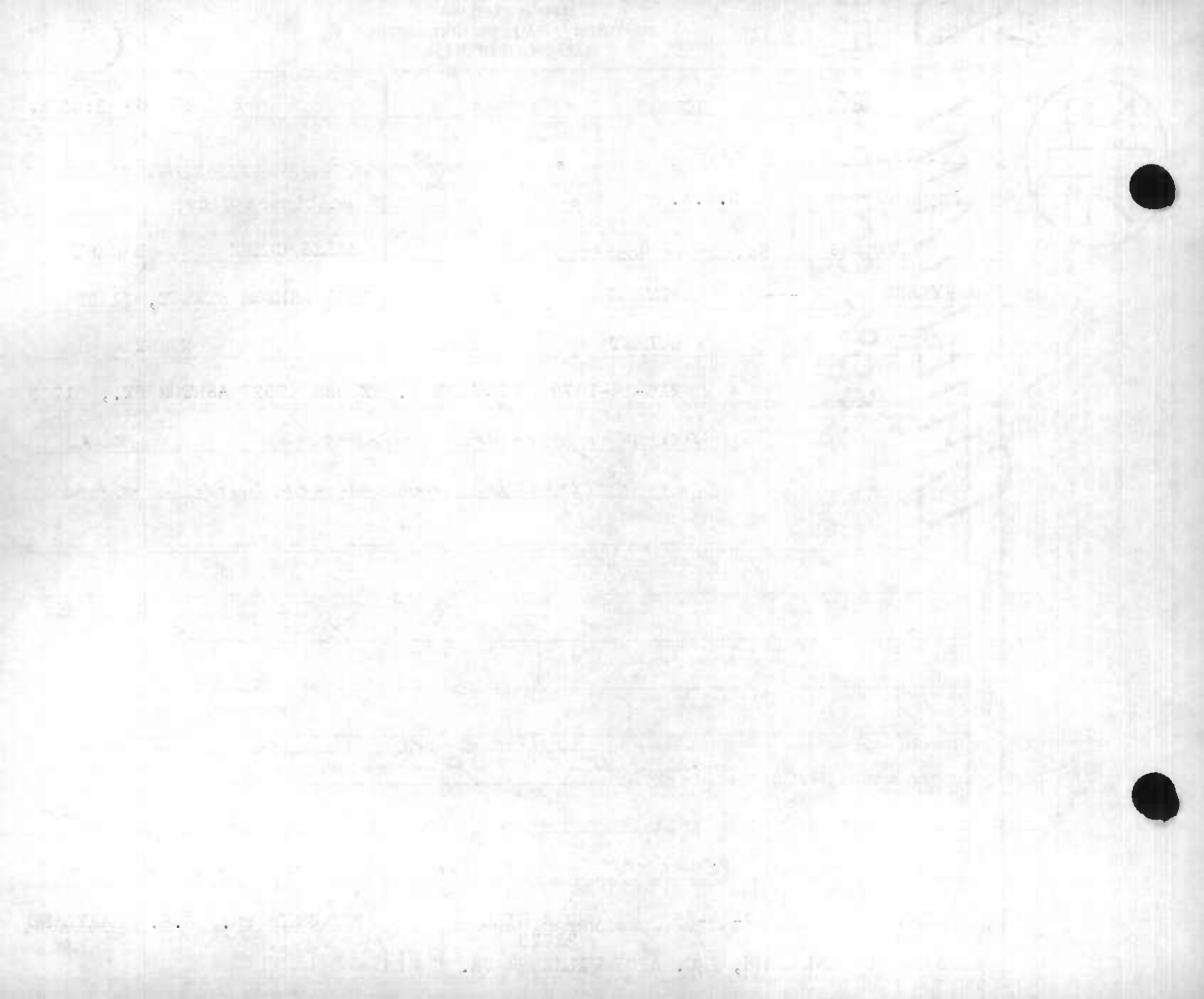
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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH REBECCA STUBBS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 23 85 | | | |
| 3. SEX
FEMALE | | | | 2b. HOUR
3:45 A.M. | | | |
| 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 28 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
BAKERY | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
KARL EULERT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALMA HORST | | 13e. STREET ADDRESS
2027 ASHTON STREET, 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-16-1879 | | 17. INFORMANT ADDRESS
BENJAMIN B. STUBBS 2027 ASHTON ST., 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS
YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/22 , 19 85 , to 2/23 , 19 85 , that (we) lost
saw the deceased alive on 2/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Steven Howard Pearlman | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN HOWARD PEARLMAN | | | | 22e. ADDRESS
ST. AGNES HOSPITAL, 500 J. CATON AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BROOKLYN PK. A.A. MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KATHERINE M. SUCHTING | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 17 85 | | | | 2b. HOUR
2:20 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 11 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5220 York Rd. 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Ryan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Gosnell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219 01 6680 | | 17. INFORMANT
Frederick W. Suchting | | | | ADDRESS
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Refractory Congestive Heart Failure | | | | | | | | 1 month | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Heart Disease | | | | | | | | years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Chronic Renal Failure, COPD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 6 19 85 , to FEB 17 19 85 , that (I) (we) last saw the deceased alive on FEB 17 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Susan G. Weiner M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUSAN G. WEINER | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
2-18-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. z Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Henry W. Jenkins & Sons Co., Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

KATHERINE M. BUCHTING

Female
White
Born July 11, 1917
BALTIMORE CITY

BALTIMORE
ALTON MEMORIAL HOSPITAL

Married
Mary Ryan
1220 York Rd. Baltimore
Cecil

210 of 6800 Frederick W. Bunting

Handwritten notes and stamps, including a large circular stamp with the letters "M" and "W" inside.

ALTON MEMORIAL HOSPITAL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 7 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Owings Summers | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 3 85 | | 2b. HOUR
1 PM M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 22 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3406 Wilkens Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
Balto., Md.
3406 Wilkens Ave. #21229 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gillis Owings | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella L. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
? | 17. INFORMANT
ADDRESS
3406 Wilkens Avenue Balto., Md.
Miss. Bettie O. Summers #21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Right cerebrovascular accident with</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Left hemiparesis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Starfish carcinoma, Hypertension</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10</u> 19 <u>79</u> to <u>death</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/1/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Albin Kutt</i> | | DEGREE
MD | | 22c. DATE SIGNED
2/4/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALBIN KUTT | | 22e. ADDRESS
1001 Pine Heights Ave, Balto MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Feb. 5, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave.
#21229 | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85-04876

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|---------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SHIRLEY A SUTHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1985 | | 2b. HOUR
5:02 P ^M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 11 1942 | | |
| 6. AGE
(IN YEARS LAST BIRTHDAY)
42 YRS. | | 7. CITIZEN OF WHAT COUNTRY?
U.S.a. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Alabama | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | | | | |

| | | | | | | |
|---|--|--|---|--------------------------------|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE North MARYLAND COUNTY
Mecklenburg | | | 13b. CITY OR TOWN
Charlotte | | 13c. STREET ADDRESS / ZIP CODE
6649 Rumble Road 28213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Marvin L. Brown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Mae Joyner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
417-54-8814 | | 17. INFORMANT
Eugene Suther | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>liver failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>veno-occlusive disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute myelogenous leukemia</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
2 weeks
6 months | | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Bone marrow transplant</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION
CITY OR TOWN COUNTY STATE | | | |

| | | | |
|---|--|--|--|
| 22a. I certify that (1) (this hospital) attended the deceased from <u>February 1, 1985</u> , to <u>February 15, 1985</u> , that (1) (we) lost saw the deceased alive on <u>February 15, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Joseph M Molina MD</u> | | DEGREE | |
| 22c. DATE SIGNED
<u>2/15/85</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JOSEPH M MOLINA</u> | | 22e. ADDRESS
<u>JHH</u> | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-21-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Chestnut Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Salisbury, Rowan, North Carolina | |
| 24. FUNERAL DIRECTOR
NAME
Marzullo Funeral Service | | | | ADDRESS
Reisterstown, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Lia Davidson-Randall</u> | | | |

1 40 20 01 2 6
A 13 91 NC 17 11 11

U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20330
MEMORANDUM
TO: THE SECRETARY
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which are circled or underlined, but the specific content cannot be accurately transcribed.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|----------------------------|--|-------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | 2b. DATE ESTI-
MATED | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Creole | | Sutton | | | | | | 2/ 6/ 19 85 | | 4:59 | | | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| FEMALE | | BLACK | | 2 - 12 - 50 | | 34 YRS. | | | | | | 2/ 6/ 19 85 | | | | | | | |
| 7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| SOUTH CAROLINA | | USA | | | | Baltimore City, MD. | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 1506 McCulloch Street | | DISABLED | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1506 McCULLAH STREET | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | | | |
| VERNON | | SUTTON | | | | LOUISE | | MULDROW | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| | | | | PEARLINE ROANE | | 3003 LYTTLETON ROAD | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| | | Acute & Chronic Ethanolism | | Fatty Liver | | | | | | | | | | | | | | | |
| | | Chronic Alcoholism | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE
SIGNED | | 2/6/85 | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Gregory R. Kauffman, M.D. | | ADDRESS | | 111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| BURIAL | | 2-12-85 | | KING MEMORIAL PARK | | BALTIMORE, MARYLAND | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| E. L. PHILLIPS FUNERAL HOME 1721 N. MONROE ST. | | | | FEB 15 1985 | | Julia Davidson-Randall | | | | | | | | | | | | | |

1 - 11 - 50 34

SOUTH CAROLINA

DISABLED

1506 HILLMAN STREET

BALTIMORE

MARYLAND

STATION

LOUISIANA

STATION

NEW YORK STATION

RESIDENT BOX 3005 EYLLISTON ROAD

DAVID G. WATSON

2-11-55 KING MEMORIAL PARK

URIAL

E. A. PHILLIPS GENERAL & CO. 1001 N. GARDEN ST. LOS ANGELES 24, CALIF.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|--|---|---|--------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Willie Sutton | | | | | | | | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
2-16 1985 | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 27 34 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
50 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
2-16 1985 | | 24 HOUR
12:54 p. M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1712 Lemon Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1712 Lemmon Street 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clarence Sutton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julie Mims | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | 16b. SOCIAL SECURITY NO.
258-42-0507 | | 17. INFORMANT
ADDRESS
Maria Thornton 1712 Lemmon Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | TITLE (SPECIFY)
Acting Chief | | | | | | DATE SIGNED
2-21-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdowne, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

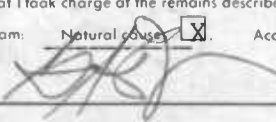
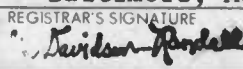
3



WANT-ED
RABBIT MOTTO 2002

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|--|---|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Walter T/ Swayne | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2/ 5/ 19 85 | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR 06 02 1914 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2/ 5/ 1985 | 2b. HOUR
8:25 P.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21201 8 Charles Plaza - Balto. Md. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dale Swayne | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen Easley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-01-5684 | | 17. INFORMANT
Mrs. Elsie Salmon - | | ADDRESS
6304 Danville Ave
Balto., Md. 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2/6/85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
02/09/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Dabrowski - 1005 Dundalk Avenue. 21224 | | | | 25a. DATE REC'D BY REGISTRAR
FEB 11 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

Editorial - 1005 Dundalk Avenue, 21224

02/09/82 London Park

Baltimore, Md.

212-01-2004

Mrs. Blaise Kaimon -

No

Date

Swynne

Helen

Basley

Barryland

Baltimore

X

8 Charles Plaza - Baltimore, Md.

Barryland

U.S.A.

Male

08 02 1914 70

12

Insurance

Retired

21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 8 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GLORIA G. SWEIGART | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 23, 1985 | | 2b. HOUR
6:15A_M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
February 23 1985 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | 12b. KIND OF BUSINESS OR INDUSTRY
Burch's Restaurant | |
| 13a. STATE
Maryland | | | 13b. COUNTY
--- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Holthaus | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Linder | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
Richard Sweigart 733 High Plain Dr. 21014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Unreopsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>urinary tract infection</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>renal failure</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>unknown</u>
<u>unknown</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/85</u> , 19 <u>85</u> , to <u>2/23</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Michael R. Saitta</u> | | DEGREE
<u>M</u> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2-23-85</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL R. SAITTA | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Feb. 16 '85 | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler, Inc. | | ADDRESS
1901 Eastern Ave 21201 | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
NORRIS F. SWETLAND | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-18-85 | | 2b. HOUR
11 15 PM |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
4 21 22 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Court Reporter | 12b. KIND OF BUSINESS OR INDUSTRY
Legal | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Pr. George | 13c. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13d. STREET ADDRESS
2600 Keating St. 20748 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Earle V. Swetland | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Hurley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579-16-2353 | | 17. INFORMANT
ADDRESS
Adelaide D. Danzi same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory and Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Small Cell Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I (this hospital) attended the deceased from 02/05 , 19 85 , to 02/18 , 19 85 , that (I (we) lost saw the deceased alive on 02/18 , 19 85 , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Paul D. Cardi, MD | | DEGREE
MD | | 22c. DATE SIGNED
02/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul D. Cardi, MD | | 22e. ADDRESS
MERCY HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/22/85 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Md. |
| 24. FUNERAL DIRECTOR
NAME
G.P. Kalas | | ADDRESS
6160 Oxon Hill Rd. Oxon Hill, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
G. Davidson-Randall | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Catherine Mae Swope | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 2, 1985 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
August 20, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5520 Nome Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY
Montgomery Ward |
| 13a. STATE
Maryland | 13b. COUNTY
-- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5520 Nome Ave. 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur Snoots | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Dillow | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
Baltimore, MD
Mr. Charles Swope | | ADDRESS
5520 Nome Avenue | |

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

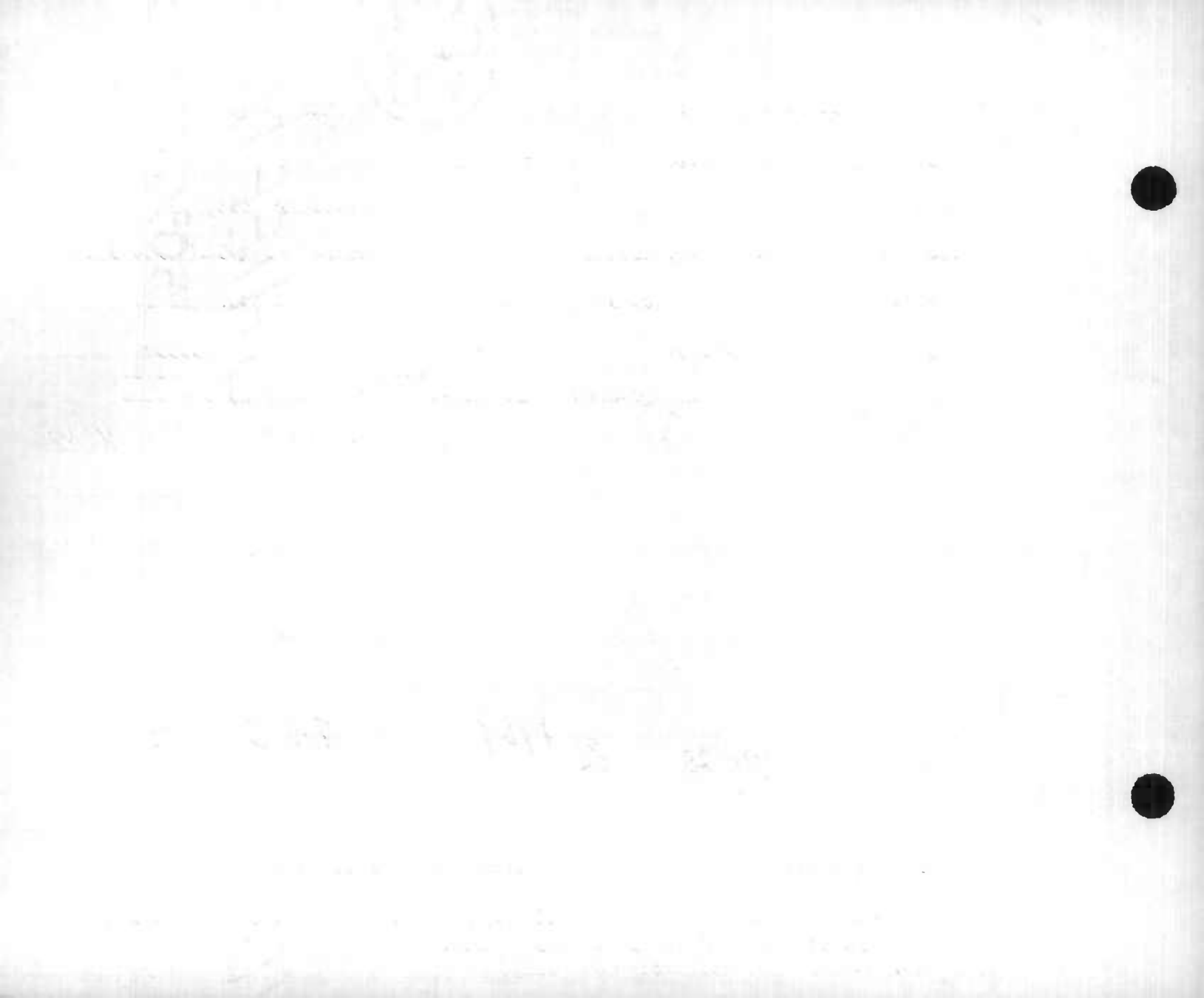
| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 25 1985 to Feb 2 1985, that (I) (we) last saw the deceased alive on Jan 25 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Dr. Joseph Shear | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
2-4-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Joseph Shear | | 22e. ADDRESS
6715 Park Heights Ave. | |

| | | | |
|--|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-6-85 | 23c. NAME OF CEMETERY OR CREMATORY
Knoxville Reformed Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Knoxville Frederick MD |
| 24. FUNERAL DIRECTOR
NAME Loring Byers Funeral Directors, Inc.
8728 Liberty Rd. Randallstown, MD 21133 | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PRINT "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 04883 | | | |
|---|--|------------------|--|--|--|---|--|---|--|---|--|------------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Wilford E. Swope | | | | | | | | | | 2. DATE KNOWN OF DEATH
ESTIMATED
2 5 1985 | | 2b. HOUR
8:05 | |
| 1. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 8, 1931 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
2 5 1985 | | 2d. HOUR
8:05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital Balto. Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY
Frieze | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. IN CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1449 Light St. Balto. Md. 21230 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Raymond ----- Swope | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary ----- Phillips | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes Korean | | | | 16b. SOCIAL SECURITY NO.
215-28-2245 | | 17. INFORMANT
ADDRESS
Mr. Richard W. Swope, 207 Kaufman Rd. Parkton Md. 21120 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Smoke inhalation</u>
8902
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6:48 AM 2 5 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
House fire | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1449 Light Street, Baltimore MD. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulting from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED
2/5/85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Feb. 8, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vet. Cem. Crownsville | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAMES
McCurly Funeral Home, 1300 E. Fort Ave. Balto. Md. 21230 | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 7 1985 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |

THE UNIVERSITY OF CHICAGO

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Agnes TALBOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 7 1985 | | 2b. HOUR
1:15 PM | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 30, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KESWICK | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Fidelity & Deposit | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas J. Talbott | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bridget Burke | | | 13e. STREET ADDRESS / ZIP CODE
3101 White Ave. 21214 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
215-10-1428 A | | 17. INFORMANT
ADDRESS
Mr. Charles J. Talbott Same as # 13 E | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A SEVD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 DAYS</u>
<u>10 YRS</u> | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>3-1</u> 19 <u>79</u> , to <u>2-7</u> 19 <u>85</u> , that (we) lost
saw the deceased alive on <u>2-7</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John F. Hartman MD</u> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>2-7-85</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN F. HARTMAN MD | | | 22e. ADDRESS
700 W. 40th St. Balto. Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-9-85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Funeral may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

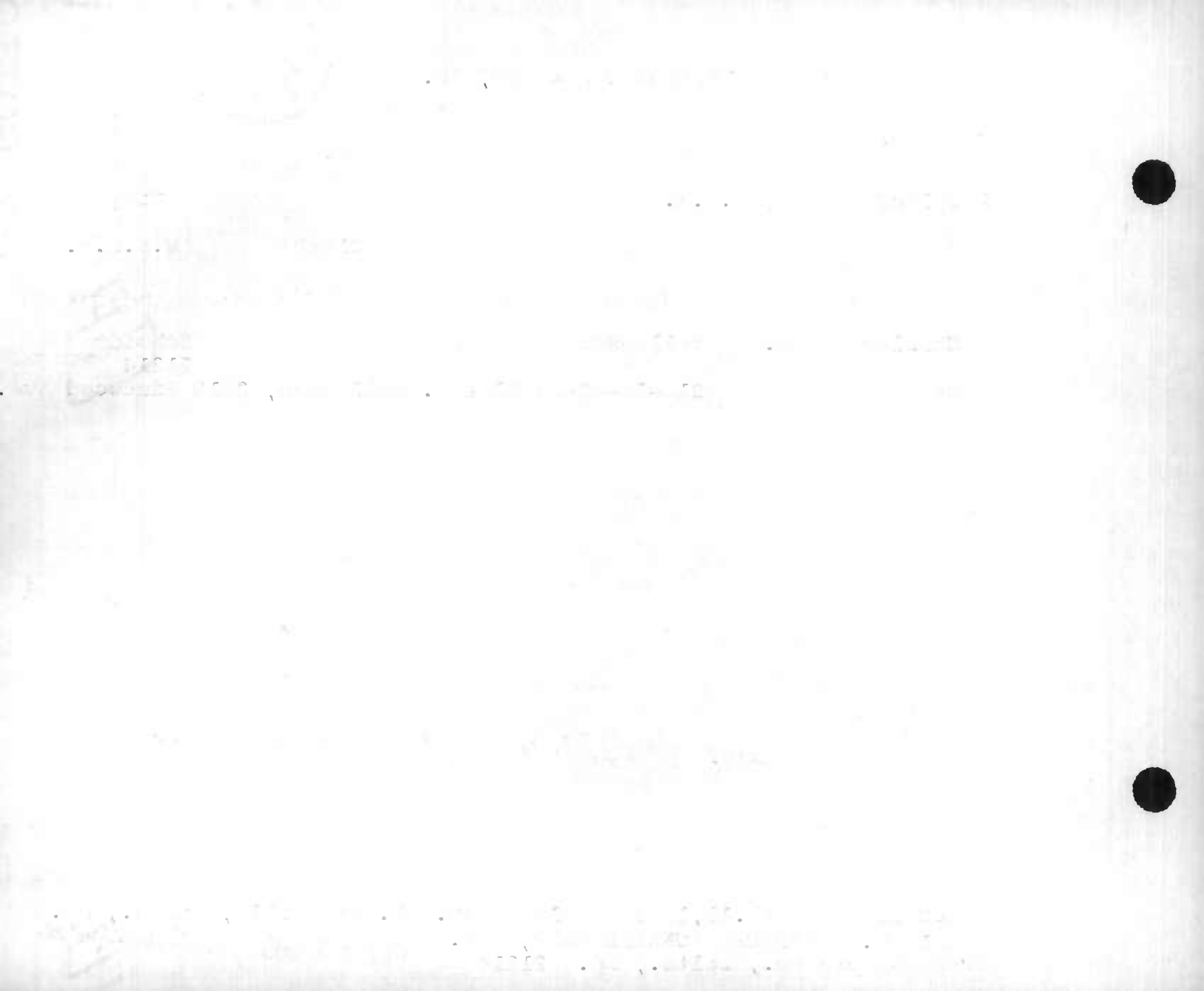
8504885

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
AKA: CARL WILLIAM TALLAGSEN, SR.
CARL W. TALLAGSEN | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 9 / 1985 | | 2b. HOUR
10 20 PM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 / 26 / 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Good Samaritan Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.P.S. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
md | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles J. Tallagsen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Schmidt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
216-28-4249 | | 17. INFORMANT ADDRESS
Alma E. Tallagsen, 2818 Pinewood Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/4/1985 to 2/9/1985 , that (I) (we) last saw the deceased alive on 2/9/1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. Jaziri | | DEGREE
M.D. | | 22c. DATE SIGNED
2/9/1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALID A. JAZIRI M.D. | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 13, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville Balto. Md. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
FEB 13 1985 | | | |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

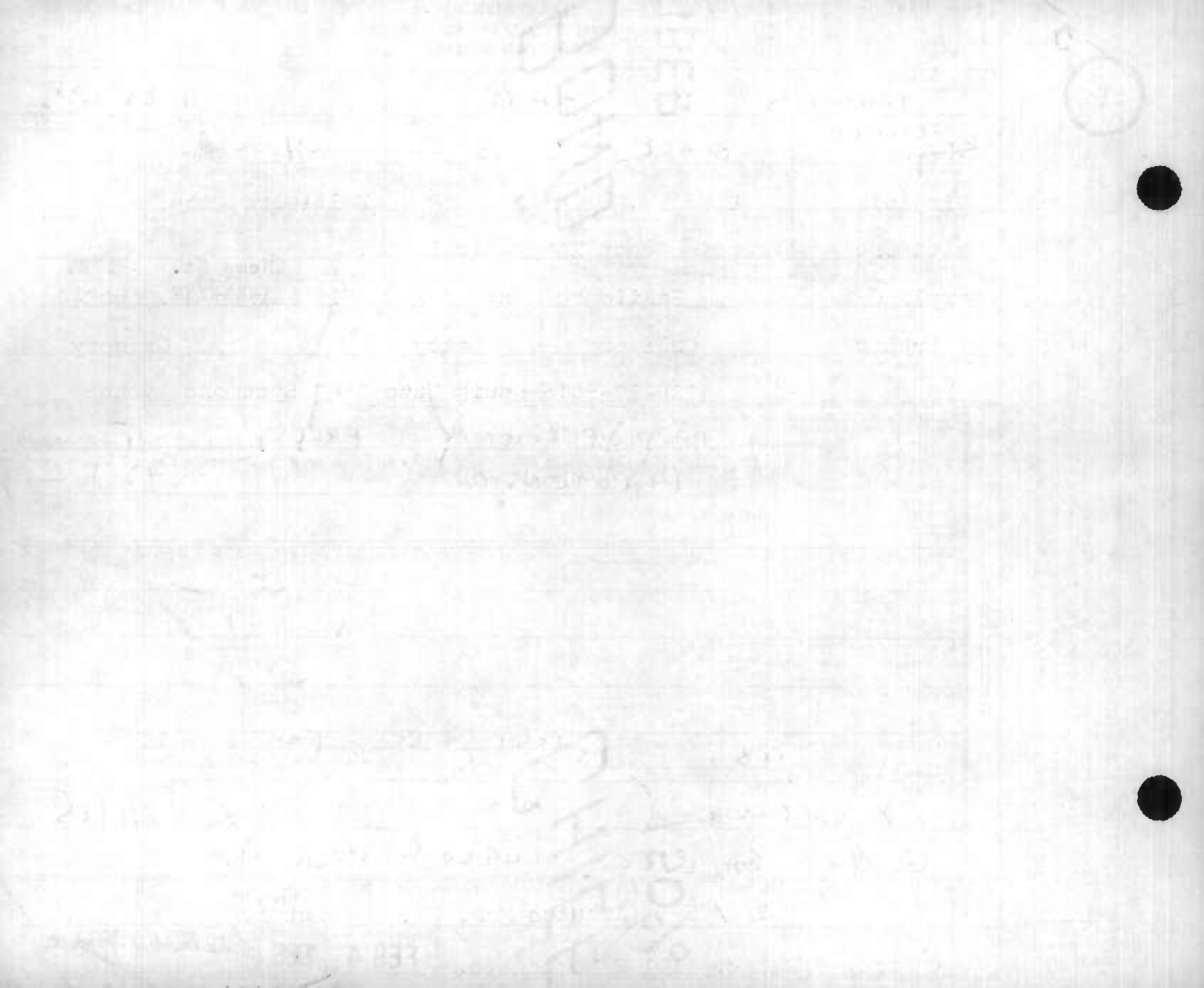
Item 13c per phone 2/8/85 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FRANCES R TATE | | | MONTH DAY YEAR
2 1 85 | | | 6:55 AM | | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH MONTH DAY YEAR
5 12 17 | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Ctr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Luther Galimore | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Betty Gregory | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
220-30-5815 | | | 17. INFORMANT ADDRESS
Louis Tate 2509 Sycamore Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minute
72 hr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 1 , 19 85 to FEB 1 , 19 85 , that (I) (we) last saw the deceased alive on FEB 1 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Gerard Gallocc | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/1/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GERARD GALLOCC | | | 22e. ADDRESS
4940 Eastern Ave. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
2/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arbutus Md. | |
| 24. FUNERAL DIRECTOR NAME
Wm C March F/H Inc. | | | ADDRESS
1101 E North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
J. A. Davidson-Randall | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

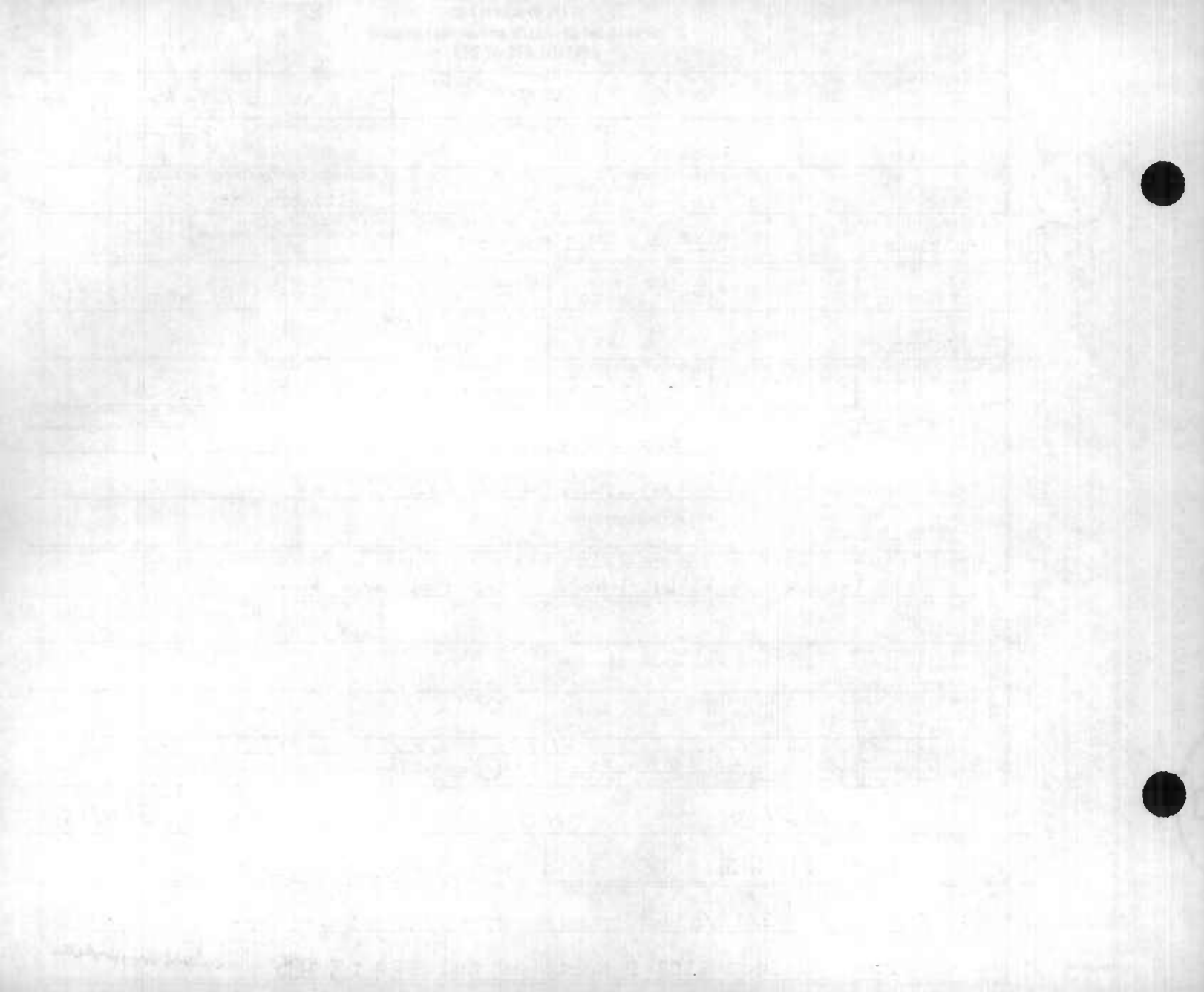
8 5 0 4 8 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
CHARLIE | MIDDLE
N. | LAST
TAYLOR | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 10 / 85 | | | 2b. HOUR
12:15 PM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 20 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2307 Robb Street 21218 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
231-07-7456 | | 17. INFORMANT ADDRESS
Jerry Allen 2307 Robb Street | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) R/O Urosepsis
DUE TO, OR AS A CONSEQUENCE OF
(b) Urinary tract infection
DUE TO, OR AS A CONSEQUENCE OF
(c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pneumonia of Lt. lobe R/O ischemic bowel | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/11/85, to 2/10/85, that (1) (we) lost saw the deceased alive on 2/10/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
F.M. Bluth | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/10/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F.M. Bluth | | | 22e. ADDRESS
Union Memorial Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | ADDRESS
1101 E North Avenue | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

BP



FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

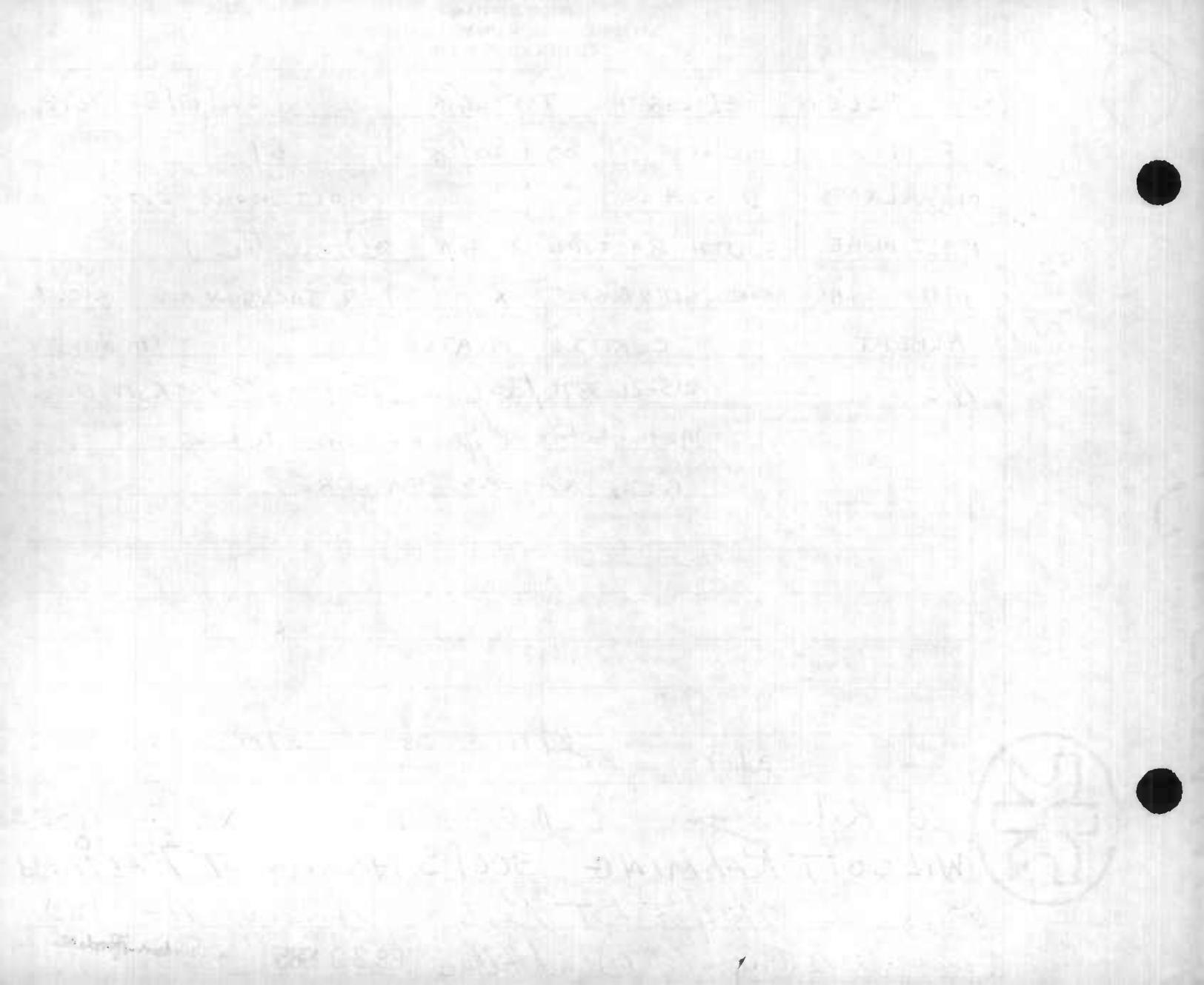
| | | | | | |
|---|--|--|---|--|----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN ELIZABETH TAYLOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02/17/85 | | 2b. HOUR
10:15 AM |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
03/30/15 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
69 | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 15. KIND OF BUSINESS OR INDUSTRY |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
ANNE ARUNDEL | | |
| 13c. CITY OR TOWN
GLEN BURNIE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
7 JACKSON AVE 21061 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT CURTIS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MYRTLE THOMAS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-26-3871 | | 17. INFORMANT
ADDRESS
Raymond Taylor - 7 Jackson Ave 21061 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Hypernephroma to lung
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11 , 19 85 , to 2/17 , 19 85 , that (I) (we) last saw the deceased alive on 2/17 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. Rahming | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILCOTT RAHMING | | 22e. ADDRESS
3001 S. Hanover ST BALTO. MD 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ST Rest | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hanover AA Md | | 23e. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
Funell B. Oden - 163 R Druid Hill Ave | | 25. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.



NOT M.E. CASE PER DR A. DIXON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. PER MR. HENRY

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 8 9

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MABEL TAYLOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 1985 | | 2b. HOUR
2:00 M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6-19-26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1503 E. Federal St. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Brown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Yarber | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
245-34-1219 | 17. INFORMANT ADDRESS
John Taylor 1503 E. Federal St. 21213 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPERKALEMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) URMIC COMA
DUE TO, OR AS A CONSEQUENCE OF
(c) RENAL FAILURE | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 DAYS
7 DAYS
1 Year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
JOHNS HOPKINS HOSPITAL | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/4/85 , 19 85 , to 2/28 , 19 85 , that (I) (we) last saw the deceased alive on 2-28- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Gene Howard | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/28/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gene Howard | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3-5-85 | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Nat. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Chas. A. Rice FSPA 1300 Eutaw Place | | | 25a. DATE REC'D. BY REGISTRAR
MAR 7 1985 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
J. Davidson | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

04890

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RAPHAEL Marie TEGGES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 1 85 | | | 2b. HOUR
215^PM | | | | | |
| 3 SEX
FEMALE | | 4 RACE
White | | 5. DATE OF BIRTH
12th 03 06 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT HOSPITAL BALTIMORE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Housework | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Middle River | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1300 Burke Road 21220 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adolph Perouty | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Caroline Zimmerman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-16-6382 | | 17. INFORMANT ADDRESS
Charles E. Tegges 1300 Burke Road 21220 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia COPD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 85 , to 2-1 , 19 85 , that (I) (we) lost
saw the deceased alive on 2-1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Sher Afzal Hashmi MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-1-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHER AFZAL HASHMI | | | | | | 22e. ADDRESS
2600 LIBERTY RD BALTIMORE 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-5-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eastwood, Balto., Co., Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | | | | | ADDRESS
6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

3. *Explain the importance of the following factors in the development of a country's economy:*

$$X^{\vee} = \bigoplus_{i=1}^n \mathbb{C} \alpha_i^{\vee} = X^{\vee} \cap \mathfrak{h}^{\vee}$$

15

005/5 1000 5000 005/5 1000 5000

10/10/18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

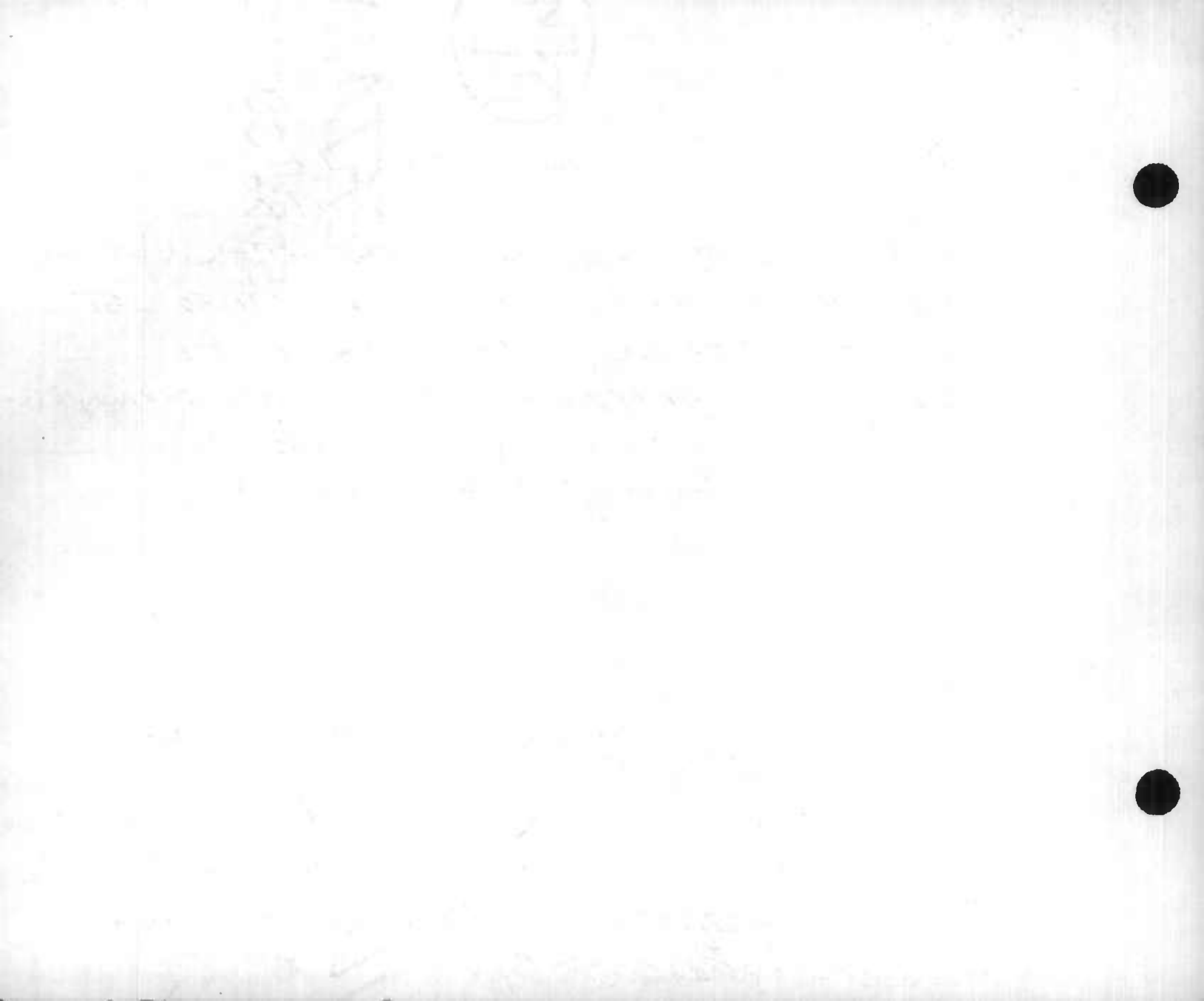
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John T. Terzi | | 2a. DATE OF DEATH
MONTH DAY YEAR Feb. 24 '85 | | 2b. HOUR
6:45 PM | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR Aug 14 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY?
✓ | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorton Medical | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) THE SETTER | |
| 13a. STATE
MD. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST JOSEPH TERZI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST MARIA ZAVAYLOTTI | | 16. STREET ADDRESS / ZIP CODE
1010 STILES ST. 21202 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 17b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 216 05 7966 | | 17c. INFORMANT
ADDRESS JOSEPH TERZI 1928 DENBURY RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Stomach metastases
DUE TO, OR AS A CONSEQUENCE OF (b) Urinary retention, assoc. "a"
DUE TO, OR AS A CONSEQUENCE OF (c) testes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 12 , 19 85 , to Feb. 24 , 19 85 , that (I) (we) last saw the deceased alive on Feb. 24 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J. W. Reed | | DEGREE
MD. | | 22c. DATE SIGNED
2/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. W. REED | | 22e. ADDRESS
611 S. CHAS. ST. BALTO. MD. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
2/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garden of Faith | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | 23e. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Della Lore + Son 322 S. 4th | | 25. REGISTRAR'S SIGNATURE
John T. Terzi | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 4 8 9 2 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret Thacker | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 2 13 1985 | | | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR 5 25 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
133 N. Luzerne Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS
133 N. Luzerne Ave. 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanley Ditty | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Christian | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
406-01-7581 | | 17. INFORMANT
ADDRESS
W. Barton Thacker 133 N. Luzerne Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic small cell carcinoma of the lung.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 4 , 19 85 , to FEBRUARY , 19 85 , that (I) (we) last saw the deceased alive on February 4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Paul Cerano MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL CERANO MD | | | | 22e. ADDRESS
JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hills Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
B. Dabrowski & Son | | | | ADDRESS
2818 E. Baltimore St | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Henderson | | | |

UNITED STATES
DEPARTMENT OF JUSTICE

2

| Case No. | Plaintiff | Defendant | Amount | Filed | Term |
|------------|-----------------|-----------------|----------|---------|---------|
| 100-1-2501 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2502 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2503 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2504 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2505 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2506 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2507 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2508 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2509 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |
| 100-1-2510 | James M. Lister | James M. Lister | \$100.00 | 10/1/50 | 10/1/50 |



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 9 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD M. THAMARUS | | | 2a. DATE OF DEATH
2-3-85 | | | 2b. HOUR
M | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-25-1929 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY - MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1620 PLUM ST. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY
PAINT Co. | | | |
| 13a. STATE
MD. | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1620 PLUM ST. 21226 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARVIN THAMARUS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GLADYS SMITH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES. | | | 16b. SOCIAL SECURITY NO.
KOREAN | | 17. INFORMANT
Mrs. Richella C. Puskas | | ADDRESS
3028 LINWOOD AVE. | | 21234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Dysrhythmia, acute
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent Cardiac Dysrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 minutes
Severals wks | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Previous myocardial infarctions | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2/85 to present , that (I) (we) lost saw the deceased alive on Feb 2/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Colvin C. Carter MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/5/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Colvin C. Carter | | | | | | 22e. ADDRESS
4700 Pennington Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2-6-85 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD Cem | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Harthill - 7527 Starford Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

154
175
190
300
921
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Baltimore City

U.S.A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 9 4

REG. NO.

1- FOR
STATE
REGISTRAR

T wedding Brnd.

77 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE F. THOMAS

78 2a. DATE OF DEATH MONTH DAY YEAR 2/17/85 2b. HOUR 11:57 A.M.

79 3. SEX Female 4. RACE Col. 2 5. DATE OF BIRTH MONTH DAY YEAR 3-4-1906 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS

80 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greenville, S.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

81 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Gen. Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY

82 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY BALTO. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 21216 3901 Carlisle Ave

83 14. FATHER'S NAME FIRST MIDDLE LAST Jerry Fowler 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Jefferson

84 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Mrs. Hattie Coats 2506 Violet Ave.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ANOXIC ENCEPHALOPATHY

DUE TO, OR AS A CONSEQUENCE OF

(b)

SEVERE RENAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c)

CONGESTIVE HEART FAILURE

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

9 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

9 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/15, 19 85 to 2/17, 19 85, that (I) (we) last saw the deceased alive on 2/17, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE A.C. Chouvalit, M.D. DEGREE 22c. DATE SIGNED 2/17/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHOUVALIT, M.D. 22e. ADDRESS NORTH CHARLES GENERAL HOSP.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial 23b. DATE 2-21-85 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MD

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Joseph L. Russ 2222 W. North Ave. FEB 26 1985 Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

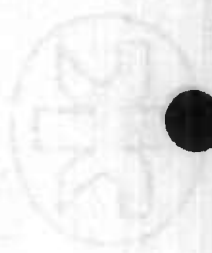
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

85 . 04895

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|---------|---|-------------------|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| Beatrice B. Thomas | | | | ESTIMATED XX 2-2 19 85 | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Black | 4 17 07 | 77 YRS. | MONTHS DAYS | | HOURS MIN. | | 2-2 19 85 | | 3:30 p. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 1110 Argyle Avenue | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1110 Argyle Ave 21201 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| George Booth | | | | Alisha | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | | | | Helen Harden 1122 Handy Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| <i>Dennis F. Smyth</i> | | | | M.D. Assistant | | | | 2-3-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., Md. | | | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| BURIAL | | 2/8/85 | | Balto. National Cem. | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | | | FEB 5 1985 | | | | <i>Davidson-Randall</i> | | | |
| Wm C March F/H Inc. 1101 E North Ave. | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 5 0 4 8 9 6
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | |
|---|---------------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Benjamin Franklin Thomas | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 2 5 19 85 | | 2b. HOUR
9:55 a.m. |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 12 34 | 6. AGE (IN YEARS)
LAST BIRTHDAY
51 YRS. | 7c. DATE PRONOUNCED DEAD
2 5 19 85 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2418 Barclay Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ed Thomas | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
May Smith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Apt. 501
May McCollum 501 E. Preston Street |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<u>Diabetes mellitus</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth, M.D.</i> | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | DATE SIGNED
2/5/85 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St. Balto., MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(15a)
BURIAL | 23b. DATE
2/8/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cemetery | 23d. LOCATION
CITY OR TOWN
Lansdowne, | COUNTY
STATE
Md. |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 1985 | | |
| ADDRESS
1101 E North Avenue | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



DMC MIAFAD
R3317 NOTED 2002

FOR
STATE
REGISTRAR

5/22/85 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 0 4 8 9 7

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST
CLARENCE
LAST
THOMAS | | 2a. DATE OF DEATH
MONTH
2
DAY
27
YEAR
85 | | 2b. HOUR
5:20
AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH
9
DAY
27
YEAR
19 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
65
YRS. | | 7. IF UNDER 1 YEAR
MONTHS
0
DAYS
0 | | 8. IF UNDER 24 HRS.
HOURS
0
MIN.
0 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Police Officer | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | |
| 14. FATHER'S NAME
FIRST
Clarence
MIDDLE
E.
LAST
Thomas | | 15. MOTHER'S MAIDEN NAME
FIRST
Isabelle
MIDDLE
Brown
LAST
Brown | | 16. STREET ADDRESS / ZIP CODE
1611 Wall Drive 21122 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
218-07-5666 | | 17. INFORMANT
ADDRESS
Mrs. Evelyn M. Thomas 1611 Wall Drive 21122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes, stroke, septal shock
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/21/85 , 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on 2/26/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. T. Church | | DEGREE
MD | | 22c. DATE SIGNED
2/27/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ACEVEDO | | 22e. ADDRESS
St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 1, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | |
| 23d. LOCATION
CITY OR TOWN
Glen Burnie | | COUNTY
Anne Arundel | | STATE
Md. | |
| 24. FUNERAL DIRECTOR
McCutty Funeral Home of Pasadena | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of choice.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 8 9 8

1 - FOR
STATE
REGISTRAR

REG. NO.

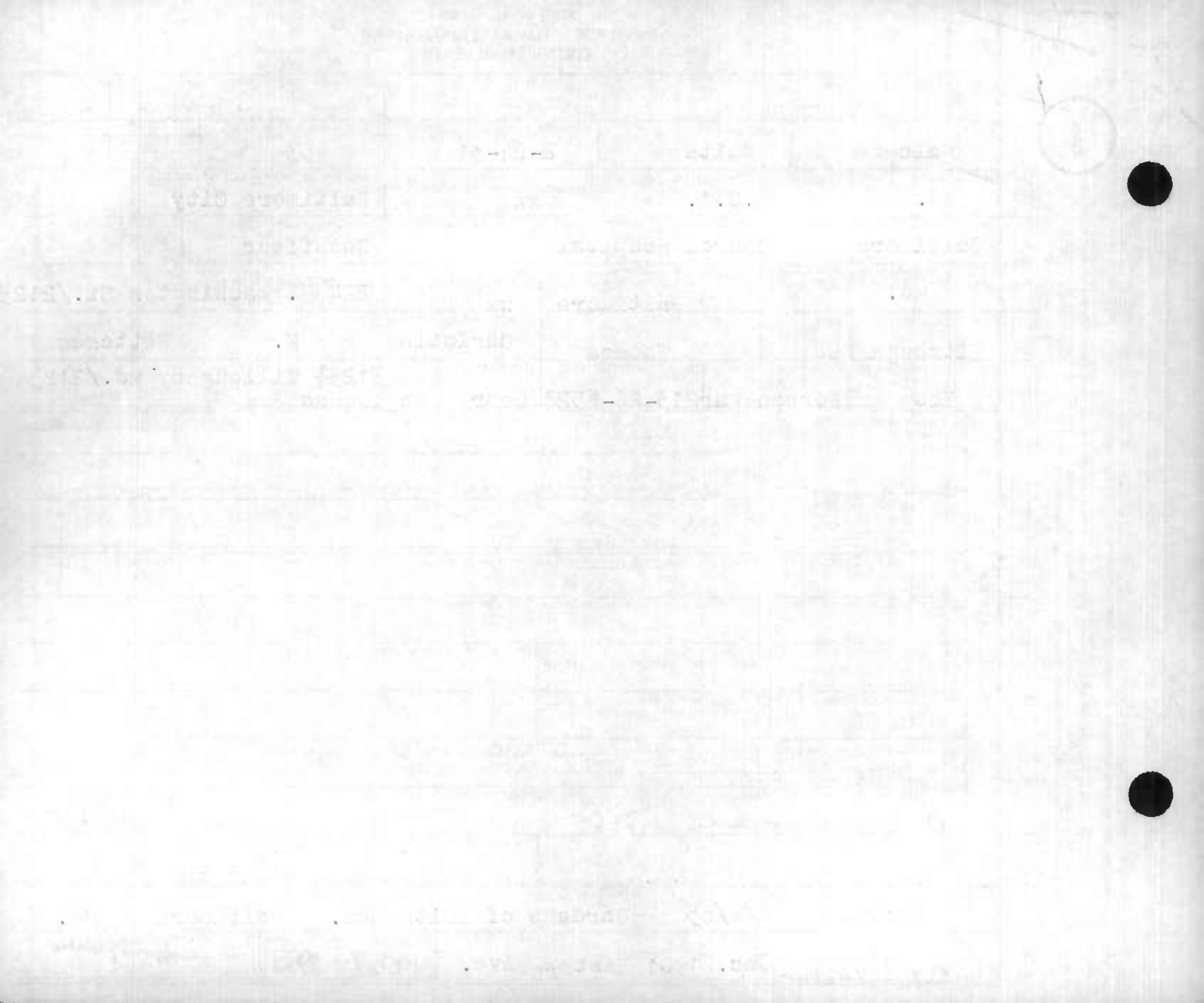
| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LAWRENCE THOMAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 5 1985 | | 2b. HOUR
3:25Am |
| 1. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2-24-31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS
MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chauffeur | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fitzhugh Lee Thomas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christine M. Hettchen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
Korean War 213-26-6528 | | 17. INFORMANT
Henry Leo Thomas | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE CARDIOPULMONARY ARREST | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) LUNG CARCINOMA WITH WIDESPREAD METASTASIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 4 19 85 to FEBRUARY 5 19 85 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on FEBRUARY 5 19 85 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE
C.S. Ramsey D.O. | | DEGREE | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C.S. RAMSEY MD D.O. | | 22e. ADDRESS
CHURCH HOSPITAL
100 NORTH BROADWAY 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler Inc. | | ADDRESS
1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Jane Davidson-Hart</i> | |

MEDICAL CERTIFICATION

29

1

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be kept with you for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical record should be made available to the coroner.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 04899 | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
LAYTERA THOMAS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 16, 1985 | | | |
| 3. SEX
Female | | | | 2b. HOUR
8:45 mp | | | |
| 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
6 12 1984 | | 6. AGE (IN YEARS LAST BIRTHDAY)
8 Months YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Dane Thomas | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Carmela Little | | 13e. STREET ADDRESS / ZIP CODE
802 C Brook Ct. Annapolis, Md. 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Carmela Little 802 C Brook Ct. Annapolis, Md. 21401 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory + cardiovascular collapse
DUE TO OR AS A CONSEQUENCE OF (b) Bronchopulmonary dysplasia Birth
DUE TO OR AS A CONSEQUENCE OF (c) Birth
Approximate interval between onset and death: 2/11/85 - 2/14/85 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 85 , to 2/16 19 85 , that (I) (we) last saw the deceased alive on 2/16 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Sharon M. Lombard MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/16/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHARON M. LOMBARD | | | | 22e. ADDRESS
600 N. Wolfe St. - Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2-20-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Hill Crest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Frederick R. Borden | | | |

BP



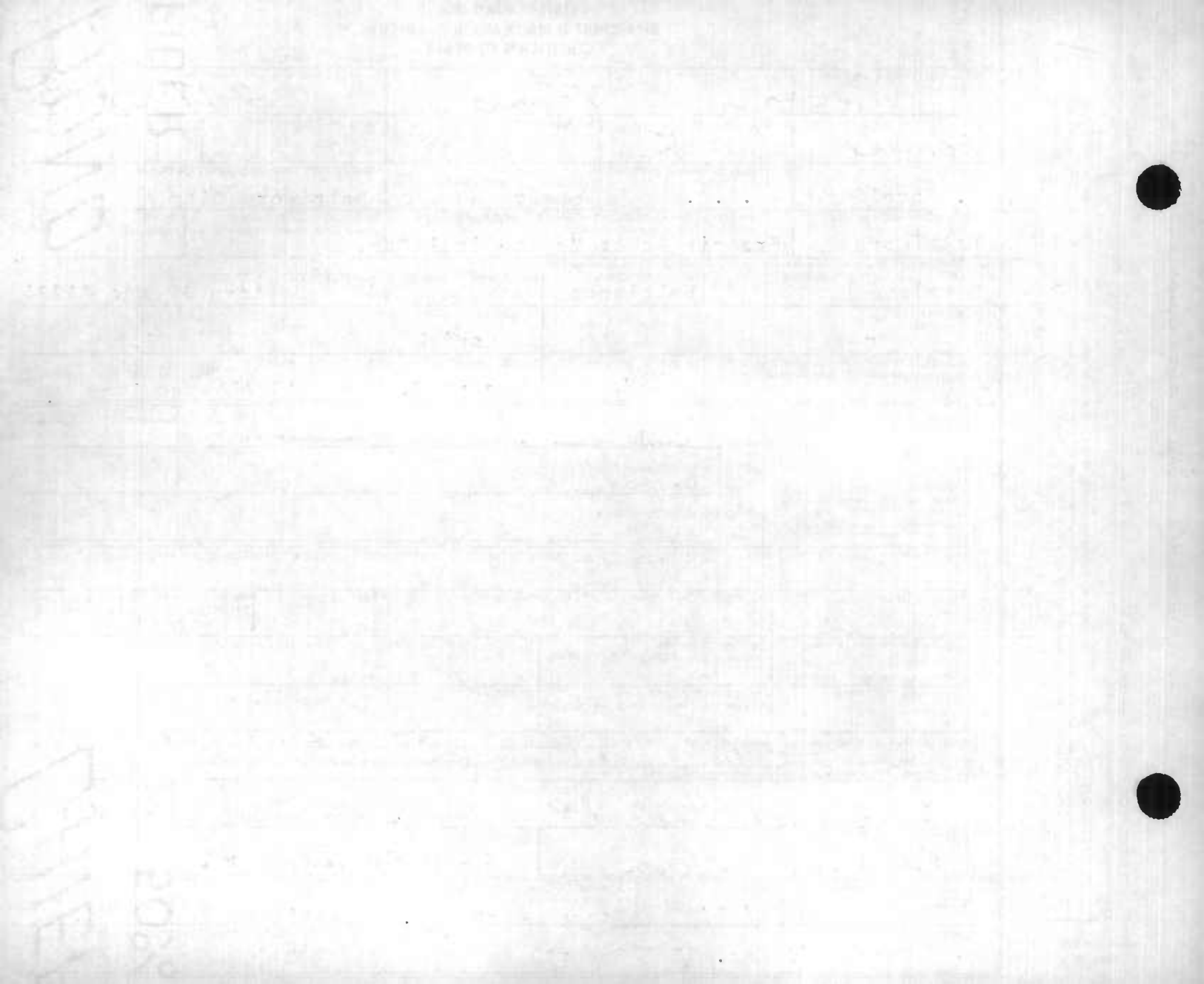
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Vieste Thomas</u> | | | 2a. DATE OF DEATH
MONTH <u>2</u> DAY <u>17</u> YEAR <u>85</u> 2b. HOUR <u>9:10</u> AM | | |
| 3. SEX
<u>Female</u> | 4. RACE
<u>Black</u> | 5. DATE OF BIRTH
MONTH <u>6</u> DAY <u>6</u> YEAR <u>05</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>79</u> YRS | | 7b. HOUR <u>9:10</u> AM |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<u>S. Carolina</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City,</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Francis Scott Key Medical Ctr.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<u>Maryland</u> | 13b. COUNTY
<u>Baltimore</u> | 13c. CITY OR TOWN
<u>Baltimore</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<u>4940 Eastern Avenue 21224</u> | |
| 14. FATHER'S NAME
FIRST <u>-</u> MIDDLE <u>-</u> LAST <u>-</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mariah</u> MIDDLE <u>Flax</u> LAST <u>Flax</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>N/A</u> | | 17. INFORMANT
<u>Thomas C. Young 13 Alberge Lane</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Dementia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 83</u> to <u>2/17</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Debra Swertheimer MD</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/18/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DEBRA SWERTHEIMER MD</u> | | 22e. ADDRESS
<u>5200 EASTERN AVE</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | 23b. DATE
<u>2/25/85</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Sacra Heart Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Co., Md.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Wm C March F/H Inc.</u> | | ADDRESS
<u>1101 E North Avenue</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>2/21 1985</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Davidson-Randall</u> | |

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|---|---|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RUSSELL THOMPkins | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 2 22 1985 | | 2b. HOUR 11:15 P | | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH 10 DAY 15 YEAR 16 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YR.
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
2 22 1985 | | 2d. HOUR 11:15 P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5309 Woodmont Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5309 Leith Road Apt. H | | | |
| 14. FATHER'S NAME
FIRST Thomas MIDDLE Thompkins LAST Thompkins | | | | 15. MOTHER'S MAIDEN NAME
FIRST Sallie MIDDLE Dillard LAST Dillard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
054-01-5134 | | 17. INFORMANT
ADDRESS Mary A. Clark 5309 Leith Road | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Ann M. Dixon</i> | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 2-23-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore, COUNTY Md. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME Wm C March F/H Inc. ADDRESS 1101 E North AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 25 1985 25b. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | |

22317 MOTOROS NO2

WALLERMAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DMMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|--|--|---|--------------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Matthew Thompson | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2--6 1985 | | | | 2b. HOUR
10:42 a. | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
4- 21-1936 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
48 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
2-6 1985 | | 2d. HOUR
10:42 a. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO MAD. | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital - DOA | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer PARKER | | 12b. KIND OF BUSINESS OR INDUSTRY
METAL | |
| 13a. STATE
MD. | | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter Thompson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Holiday | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
217-30-3308 | | 17. INFORMANT
ADDRESS
Madeline THOMPSON 507 W. Lafayette AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
2-7-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-11-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
Brown Thompson F.H. | | | | ADDRESS
1913 W. Balto St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>D. Anderson-Randell</i> | |

GREEN MOTION PICTURE

LOWE LENS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROZEL Elizabeth THOMPSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/18/85 | | | |
| 3. SEX Female | | | | 2b. HOUR 8:00 P.M. | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 15 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CASHIER | | 12b. KIND OF BUSINESS OR INDUSTRY Supermarket | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY --- 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL B. BRIDGEMAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE SALISBURY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO 217079389 | | 17. INFORMANT DEL RIO | | ADDRESS SOUTH BALTO. GEN. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE COPD
DUE TO, OR AS A CONSEQUENCE OF (c) --- | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18/85 , 19 85 , to 2/18/85 , 19 85 , that (I) (we) lost saw the deceased alive on 2/18/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Del Rio | | | | DEGREE | | 22c. DATE SIGNED 2/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Del Rio | | | | 22e. ADDRESS 3001 S. Hahoven St., Baltimore, Md., 21230 | | 22f. 21225 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/22/1985 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md. | |
| 24. FUNERAL DIRECTOR McCurly Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE John T. ... | |

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END PAGE 606

1/1/50

1/1/50

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Item 4 per phone 2/20/85 dad

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|---|---------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) <i>William J. Thompson</i> | | | 2a DATE OF DEATH
MONTH DAY YEAR
<i>2 4 85</i> | | 2b HOUR
<i>5:30 AM</i> | |
| 3 SEX
<i>M</i> | | 4 RACE
<i>Caucasian</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>7 26 09</i> | | |
| 6 AGE
(IN YEARS LAST BIRTHDAY)
<i>75</i> | | 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>US</i> | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Baltimore City</i> | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Mercy Hospital</i> | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Laborer</i> | | |
| 13a USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>MD.</i> | | 13b COUNTY
<i>BALTIMORE</i> | | 13c CITY OR TOWN
<i>BALTIMORE</i> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>unknown</i> | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>unknown</i> | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NA</i> | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
<i>232-129985</i> | | 17 INFORMANT
ADDRESS
<i>DeKora Robinson 301 W. Preston St.</i> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration</i> | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>1/25</i> 19 <i>85</i> , to <i>2/4</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>2/4</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | |
| 22b SIGNATURE
<i>Dr. St. Martin</i> | | DEGREE | | 22c DATE SIGNED
<i>2/4/85</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Dorian St. Martin</i> | | 22e ADDRESS
<i>Mercy Hosp. 301 St. Paul St.</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b DATE
<i>2-9-85</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>MT. ZION Cemetery</i> | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
<i>2222 W. North Ave. MD</i> | | 24 FUNERAL DIRECTOR
<i>RODNEY T. SYKES</i>
LIC. FUNERAL DIRECTOR | | | | |
| 25a DATE RECD. BY REGISTRAR
<i>FEB 11 1985</i> | | 25b REGISTRAR'S SIGNATURE
<i>R. T. Sykes</i> | | | | |

WILLIAM W. WILSON

93819 140700 2002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04905

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Velvia Belle Tignor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 18, 1985 | | | 2b. HOUR
7P. M | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 1, 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Tenn. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a STATE
MD | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
800 Gorsuch Ave. 21218 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Thomas E. Evans | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosie Belle Barnette | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 20 0810 | | 17 INFORMANT
ADDRESS
Hubert Tignor Baltimore, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, diabetes.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
20 yrs
15 yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
C.U.A. ; Obesity. | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 25, 1965 , to Feb. 18, 1985 , that (I) (we) last saw the deceased alive on Nov 26, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Sami Okutman | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2.19.85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sami Okutman | | | 22e. ADDRESS
Box 257 Sykesville, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-21-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Harry W. Haight | | | | | | ADDRESS
Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |

19
44
35
300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP

Handwritten notes at the top of the page, including a circled '1' on the right and some illegible text.

Handwritten notes in the middle section, featuring a circled '10' and various illegible text.

Handwritten notes in the lower middle section, including a circled '10' and illegible text.

Handwritten notes in the bottom section, including a circled '10' and illegible text.

Handwritten notes at the very bottom of the page, including a circled '10' and illegible text.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04906

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH | | MIDDLE
TIMMERMAN | | 2a. DATE OF DEATH MONTH DAY YEAR
02 14 85 | | 2b. HOUR
7:55 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 1 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED. CEN. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
MD. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
4200 CLAREWAY 21213 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES GRAP | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE VINTON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
214-14-9743 | | 17. INFORMANT
ADDRESS
BEVERLY BUCK (NIECE) 8023 DUVAL AVE.
21237 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>cerebrovascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>cardiovascular disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>diabetes</u> <u>CMP</u> <u>SP MI</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> , 19 <u>85</u> , to <u>2-14</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2-14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Charles Wendt</u> | | DEGREE
MO | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-14-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Charles Wendt MD</u> | | 22e. ADDRESS
<u>Francis Scott Key Medical C.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/22/85 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SCHIMUNEK FUNERAL HOME INC.
3331 Brehms Lane Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be completed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please attach it to the other pages. Pages 1 and 2 should be filed with the 72 hours after death. Page 3 should be filed with the 72 hours after death. Page 4 should be filed with the 72 hours after death. Page 5 should be filed with the 72 hours after death. Page 6 should be filed with the 72 hours after death. Page 7 should be filed with the 72 hours after death. Page 8 should be filed with the 72 hours after death. Page 9 should be filed with the 72 hours after death. Page 10 should be filed with the 72 hours after death. Page 11 should be filed with the 72 hours after death. Page 12 should be filed with the 72 hours after death. Page 13 should be filed with the 72 hours after death. Page 14 should be filed with the 72 hours after death. Page 15 should be filed with the 72 hours after death. 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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 04907 | | | |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST TINDALE
(TYPE OR PRINT) HARRY (TINDAL) | | | | 2b. HOUR 4:40 P | | | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 15 10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Cellies Tindale | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 218-01-7689 | | 17. INFORMANT ADDRESS Ruth Jones 932 N. Washington Street | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular accident | | | | | | | 2 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis | | | | | | | 30 yrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24 1985, to 2/29 1985, that (I) (we) last saw the deceased alive on 2/24 1985, and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE (of physician) [Signature] | | | | DEGREE | | 22c. DATE SIGNED 2/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ann C. Morrell | | | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 3/1/85 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md. | |
| 24 FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR FEB 28 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILBERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 24 1985 | | | 2b. HOUR
10:55A | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
06/06/1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TV Repair | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT TISDALE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LIZA PURCELL | | | 16. STREET ADDRESS / ZIP CODE
1645 W. NORTH AVE. # 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220070131 | | 17. INFORMANT
ADDRESS
ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) AORTIC VALVE DISEASE | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
40 minutes
8 YEARS
8 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
ANEMIOSIS SPONDYLITIS WITH PULMONARY FIBROSIS AND AORTIC REGURGITATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 85 to 2/24 19 85 , that (I) (we) last saw the deceased alive on 2/24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
C. W. Hendrix | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. W. HENDRIX | | | | | | 22e. ADDRESS
630 N. WOLFE ST., BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
2/25/84 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 28 1985 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rendell | | | |

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NOTICE

MAILED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | |
|--|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JUDITH B. TISSENBAUM | | | | | 2a. DATE OF DEATH
MONTH 2 DAY 9 YEAR 85 | | | | 2b. HOUR
3²⁰ A.M. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 12 DAY 27 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 7. IF UNDER 74 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SIWAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS
#21215 | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2500 W. Belvedere Ave. | | | |
| 14. FATHER'S NAME
FIRST ISAAC MIDDLE BORINSKY LAST ROSE | | | | | 15. MOTHER'S MAIDEN NAME
FIRST ROSE MIDDLE UNKNOWN LAST UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO.
217-03-6917 | | 17. INFORMANT MRS. MURIEL JACOBS
840 MILFORD MILL RD. #21208 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASCUD
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Renal Failure DM | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2-9-85 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 1-24-85 to 2-9-85 , that (ii) (we) last saw the deceased alive on 2-9-85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
JEFFREY M. MOLL, MD DEGREE | | | | | | 22c. DATE SIGNED
2-9-85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEFFREY M. MOLL, MD | | | | | | 22e. ADDRESS
SIWAI HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
2-10-85 | | 23c. NAME OF CEMETERY OR CREMATORY
OSHEL YAKOV-BETH ISRAEL | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | | 25. DATE REC'D BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Sol Levinson</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical attention on the part of the deceased should be indicated.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 1 0

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Leo ALFRED TORIGIAN</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2/9/85</i> | | | 2b. HOUR
<i>11:25 AM</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>CAUCASIAN</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12/29/30</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>54</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SOUTH BALTIMORE General Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Steel worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Steel</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MD</i> | | | 13b. CITY OR TOWN
<i>Baltimore City Brooklyn Park</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<i>658 Sunset Str</i> 21225 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Leo --- TORIGIAN</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Marie Barbara SEBAW</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>YES</i> | | | |
| 16b. SOCIAL SECURITY NO.
<i>KOREAN WAR</i> 218-26-9201 | | | 17. INFORMANT
<i>Anna Wingate</i> | | | ADDRESS
<i>2619 Fickelville Rd, Joppa MD</i> 21085 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Massive bilateral bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b)

Fatty liver

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Generalized atherosclerosis - Cachexia - Hypothermia (clinical)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/4</i> , 19 <i>85</i> , to <i>2/9</i> , 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>2/9</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Michael E. Klufas MD</i> | | DEGREE
<i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<i>2/9/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Michael E. KLUFAS, MD</i> | | 22e. ADDRESS
<i>3061 S. Hanover St Baltimore, MD 21208</i> | | | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Feb. 13, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gardens of Faith Cemetery, Baltimore</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>MD</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Howard K. McComas III, Abingdon, Md. 21009</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 13 1985</i> | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Davidson-Rondelle</i> | | | | | | | |

10/10/10

10/10/10

10/10/10

10/10/10

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10/10/10

10/10/10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04911

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Grace Lowe

2a. DATE OF DEATH

MONTH

DAY

YEAR

2-18-85

2b. HOUR

M

3. SEX

Female

4. RACE

Cot

5. DATE OF BIRTH

MONTH

DAY

YEAR

4-12-1908

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

76

MONTHS

DAYS

HOURS

MIN.

YRS.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Balto.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

2733 Hugo Ave

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2733 Hugo Ave 21218

14. FATHER'S NAME

Alex

MIDDLE

Locks

15. MOTHER'S MAIDEN NAME

Daisy

MIDDLE

Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

21216

Mrs. Nora Reedex 3005 Walbrook Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebrovascular accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertension, Diabetes Mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Pseudobulbar Palsy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from December 19 84, to February 19 85, that (I) (we) lost saw the deceased above, January 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

2/22/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

John P. Serlemiteas

22e. ADDRESS

Union Memorial Hosp, 35th St + Univ. Pkwy, Balt. MD

23a. BURIAL, CREMATION, REMOVAL

(TYPE)

Burial

23b. DATE

2-25-85

23c. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Lansdowne Baltimore Md

24. FUNERAL DIRECTOR

NAME

Joseph L. Russ 2222 W. North Ave.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

FEB 26 1985

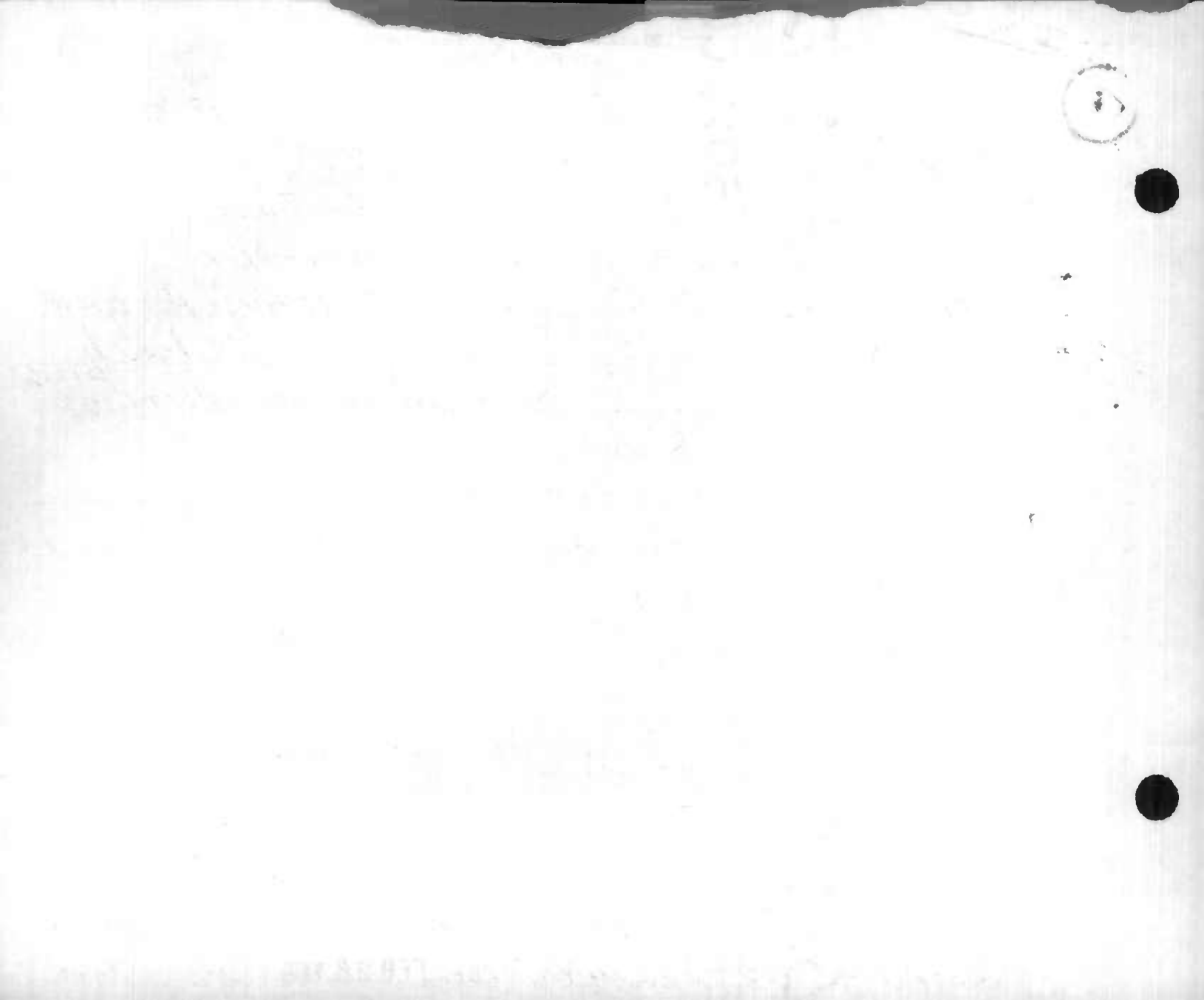
25b. REGISTRAR'S SIGNATURE

E. Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. 3504912 | | | | |
|---|--|---|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARVIN TOWNSEND. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
2 13 85 11:30 PM | | | | |
| 3 SEX
MALE | | 4 RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
10 29 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
57 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY | | | |
| 10. CITY OR TOWN OF DEATH
BAL. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETD. | | 12b. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel MD. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
BAL. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
TOWNSEND. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES. 1951 | | | | | 16b. SOCIAL SECURITY NO.
405 34 1457 | | 17. INFORMANT NAME ADDRESS
WIFE. 3944 DOLFIELD AVE 21215. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory CHF & arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (b) pul. HTN. & Resp. failure.
DUE TO, OR AS A CONSEQUENCE OF (c) ch. lung. COPD. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (4) (this hospital) attended the deceased from 1-29-1985 to 2-13-1985, that (4) (we) lost saw the deceased alive on 2-13-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Shruha Reddy. | | | | | | DEGREE | | 22c. DATE SIGNED 2-13-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.D. REDDY. | | | | | | 22e. ADDRESS SINAI HOSPITAL. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto Md | | |
| 24. FUNERAL DIRECTOR NAME Leroy O. Dyett 4600 Liberty | | | | | | ADDRESS Hgts Ave | | 25a. DATE REC'D. BY REGISTRAR FEB 20 1985 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP

FILED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
DOROTHY E. TRESS | | | | FEBRUARY 11, 1985 10 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 7, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
511 E. 38th STREET 21218 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
21218 | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
VINCENT CAMPBELL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
EDNA SCHOOLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-12-7776 | | 17. INFORMANT ADDRESS
WILLIAM S. TRESS 511 E. 38th ST. 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HWD</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
29rs
104rs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. No.
<u>Polygy & Anemia Vera</u> | | | | | | | |
| 19a. DATE OF OPERATION
2/11 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (if in this hospital) attended the deceased from <u>Oct 65</u> to <u>2/11</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Leon E. Kassel, M.D.</u> | | 22c. DATE SIGNED
2/17/85 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEON E. KASSEL, M.D. | | 22e. ADDRESS
2435 W. BELVEDERE AVE. 578-9400 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SEE INSTRUCTIONS) | | 23b. DATE
FEB. 14, '85 | | 23c. NAME OF CEMETERY OR CREMATORY
MORELAND MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE CO., MARYLAND | |
| 24. FUNERAL DIRECTOR NAME
WILLIAM E. JOHNSON | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Gina Davidson-Randall</u> | |

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

1945, 11/11/45

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph G. Trimp | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 24, 1985 | | | 2b. HOUR
10:15 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2511 Guilford Avenue 21218 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Groundskeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Maintenance | | |
| 13a. STATE
Md | | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2511 Guilford Ave. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry J. Trimp | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Louise Sweeny | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
220 22 2469 | | 17. INFORMANT ADDRESS
Patricia A. Trimp same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Asthma
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)
Life long Epilepsy - Charcot-Marie-Tooth Disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-12-1969 to 2-24-1985 that 0 we lost saw the deceased alive on 11-13-1984 , and that in 0 (our) opinion death occurred on the date and hour and from the causes stated above. 0 we (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Cesar V. Caverio | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-25-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Cesar V. Caverio | | | | | 22e. ADDRESS
5310 Old Court Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
02/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Burgee-Henss Funeral Home 3631 Falls Rd. 21211 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | 25b. REGISTRAR'S SIGNATURE | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

Acting
Cardio-Respiratory Analyst

Life and Spicing - Pleasant-More-Taste

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| DECEASED NAME FIRST MIDDLE LAST
Reginald Trogdon | | | | February 1, 1985 | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH MONTH DAY YEAR
1 5 53 | | 6. AGE (IN YEARS LAST BIRTHDAY)
32 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
1728 E. Fayette St. 21231 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Trogdon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Mary Townsend 1728 E. Fayette Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LEFT LOWER LOBE PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ALCOHOLIC HEPATITIS, CHRONIC ALCOHOL ABUSE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 30, 1985 to February 1, 1985 that (I) (we) lost saw the deceased alive on February 1, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Paul Gormley</i> DEGREE <i>MD</i> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Gormley, M.D. | | | | 22e. ADDRESS
CHURCH HOSPITAL
100 N. BROADWAY, BALTO., MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK)
BURIAL | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Anne Arundel Co, Md. | |
| 24. FUNERAL DIRECTOR NAME
Wm C March F/H Inc. | | | | 25a. DATE RECD. BY REGISTRAR
FEB 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>J. A. Davidson-Randall</i> | |



NO. 1

W. A. H. H. H.

1914-1915

NEL-3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 1 6

| | | | |
|--|--|---|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DORIS N. TROSTLE | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 24 85
2b. HOUR
7:45PM
M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 25, 1930 | |
| 6. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
Waynesboro, Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 6. AGE (IN YEARS LAST BIRTHDAY)
54
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
Waynesboro, Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Telephone Operator | |
| 13a. STATE
Md. | 13b. COUNTY
Baltimore | 13c. STREET ADDRESS / ZIP CODE
20 Walden Mill Way-21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Lewis Pittenger | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline --- Shover | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
194-26-6627 | 17. INFORMANT
20 Walden Mill Way-Catonsville, Md. 21228.
Mrs. Maryruth P. James | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Rectal carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 hours
5 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE
AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>85</u> to <u>2/24</u> 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2/24</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) <u>view the body after death</u> . | | | |
| 22b. SIGNATURE
<u>Jeffrey A. Kuller</u> MD | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-24-85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Adam Kuller | 22e. ADDRESS
Johns Hopkins Hospital, Baltimore, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/27/85 | 23c. NAME OF CEMETERY OR CREMATORY
Jacob's Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fountain Dale, Pa. |
| 24. FUNERAL DIRECTOR'S
NAME
Sterling Funeral Estate, P.A.
736 Edmondson Ave.; Catonsville, Md. 21228 | | 25a. DATE RECD. BY REGISTRAR
FEB 26 1985
25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 could be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, 1400 E. Pratt St., Baltimore, Md. 21202. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant conditions, the medical examiner must be notified of same.

48 10 315
1 2 3 4 5 6 7 8 9 10 11 12

Handwritten notes and markings, including a large 'X' and various illegible scribbles.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

04917

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Catherine Grace Truffer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/16/85 | | | 2b. HOUR
5:35 ^A M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 14 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4536 Mountain Road 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Dugan | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
218-05-5320 | | 17. INFORMANT
ADDRESS
Balto Md 21225
Madeline Stanley 156 West Meadow Road | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Widespread Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of the Colon</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Arteriosclerotic Heart Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> , 19 <u>85</u> , to <u>2/16</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph Bonelli</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/16/85</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Joseph Bonelli</u> | | | | 22e. ADDRESS
<u>St. Agnes Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto A.A. Md | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonc 4001 Ritchie Hwy Balto Md | | | | | | 25a. DATE REC'D BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pg. 2 & 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | |
| Truman | | | F | | | B | | | 1-17-85 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | USA | | | | | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Sinai Hospital | | | infant | | | none | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | | | | | 13e. STREET ADDRESS / ZIP CODE | | |
| | | | | | | | | | 00000 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | none | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | | | immediate | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) extreme prematurity | | | | | | | | | | 3 hrs. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17-85, 19-85, to 1-17, 19-85, that (I) (we) last saw the deceased alive on 1-17, 19-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| Esther Johnson MD | | | | | | 1-17-85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Esther Y. Johnson | | | Sinai Hosp. of Baltimore 21215 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | | | 1-22-85 | | | Sinai Hospital | | | Baltimore, MD | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Sinai Hospital | | | FEB 28 1985 | | | | | | | | |

MEDICAL CERTIFICATION

EDWARD

1838



EDWARD

1838

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Esther G. TURESKY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 25 1985 | | | 2b. HOUR
6:15 PM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 1, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee, U.S. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
500 W. UNIVERSITY PKWY | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
500 W. UNIVERSITY PKWY | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS Goldman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DORA FRIEDMAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
412-58-1816 | | 17. INFORMANT
ADDRESS
IRA B FADER, JR Stevenson, MD. 21153 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 5, 1985 to Feb 25, 1985 , that (I) (we) last saw the deceased alive on Feb 20, 1985 , and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
L. Mynton Gaines Jr. | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Feb 25, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. Mynton Gaines Jr. | | | 22e. ADDRESS
7800 York Rd. Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
FEB. 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
MITZVAH Cong. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CHATTANOOGA Hamilton TENN. | | |
| 24. FUNERAL DIRECTOR
NAME
Hebrew Memorial FH. 1100 Reisterstown Rd | | | ADDRESS
PRESVILLE MD | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and one of the following pages must be attached.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 2 0

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HENRY V. TURNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 6 85 | | 2b. HOUR
6 35 AM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 10 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Public School |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Russell Turner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
3609 Campfield Road
Baltimore, Maryland 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
VCDaly MD | | | | 22c. DATE SIGNED
2/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VCDaly MD | | | | 22e. ADDRESS
Sinai Hospital, Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/8/1985 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Veteran | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL HOME OR PERSON
NAME ADDRESS
Nutter & Sons 2501 Gwynns Falls Parkway
Funeral Home Inc. Baltimore, Maryland 21216 | | | 25. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04921

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Estelle Tyler | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 6, 1985 | | 2b. HOUR
M
AM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Weat Va. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1606 E. Oliver Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1606 E. Oliver St. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
229-18-1968 | | 17. INFORMANT ADDRESS
Mary Grime 1606 E. Oliver St. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**MINUTES**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Progression of Squamous Cell Lung Cancer**MONTHS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

PROGRESSIVE RENAL FAILURE

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 84 , to 2/6 , 19 85 , that (I) (we) last saw the deceased alive on JAN , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Nyam I. Levitsky | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/6/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nyam I Levitsky | | 22e. ADDRESS | |

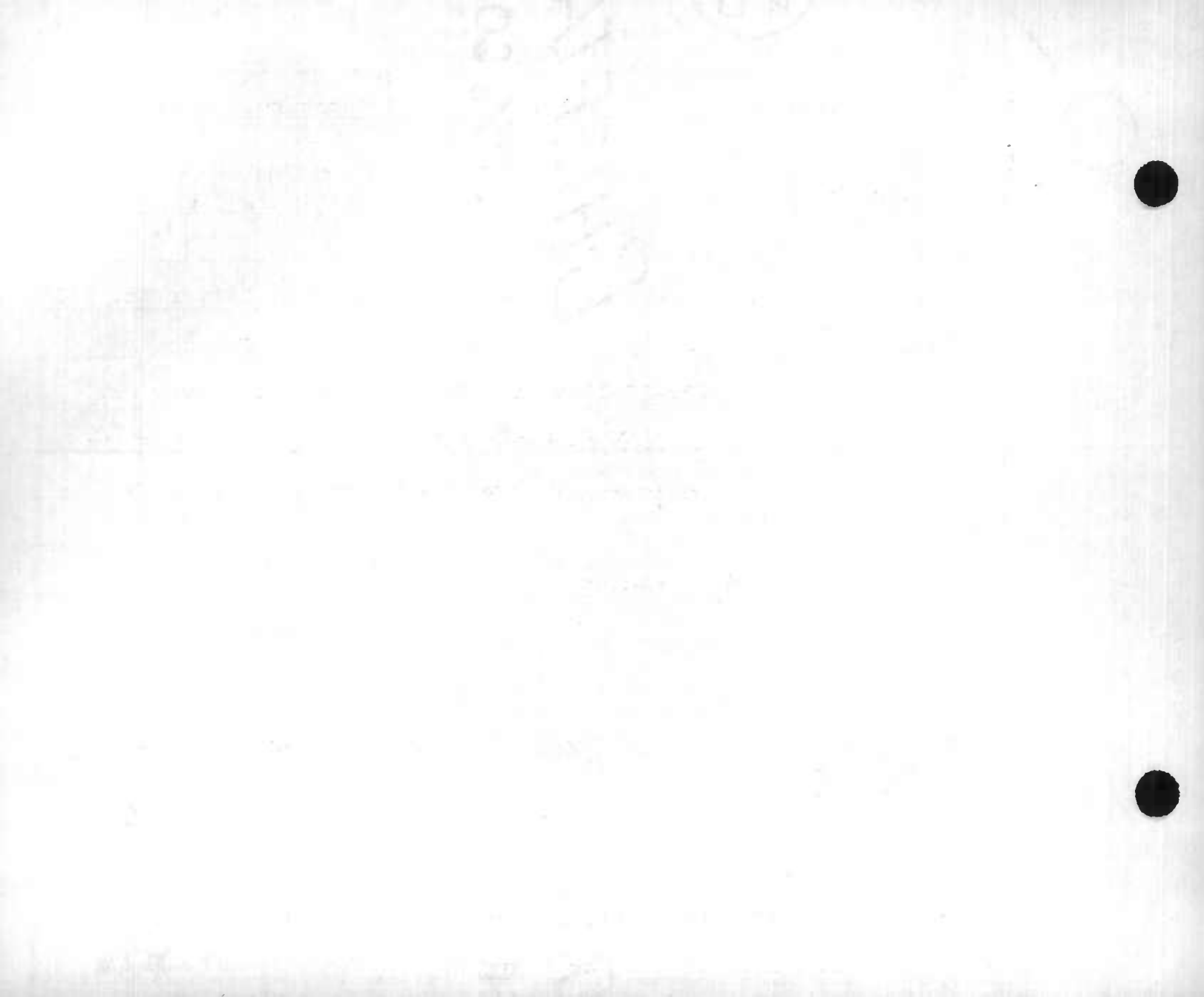
| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/11/85 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. |
|---|-----------------------------|--|---|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Avenue | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall |
|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Wayne M. Tyson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 11, 1985 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 27 54 | | 6. AGE (IN YEARS LAST BIRTHDAY)
31 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
416 Winston Ave. Apt. 4 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Tyson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Delcencia J Hicks | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
218-60-2777 | | 17. INFORMANT ADDRESS
Apt. 4
Martha A. Tyson 416 Winston Avenue | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Sarcoidosis</u> | 4 yrs |
| | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Systemic Sarcoidosis</u> | 4 yrs |
| | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

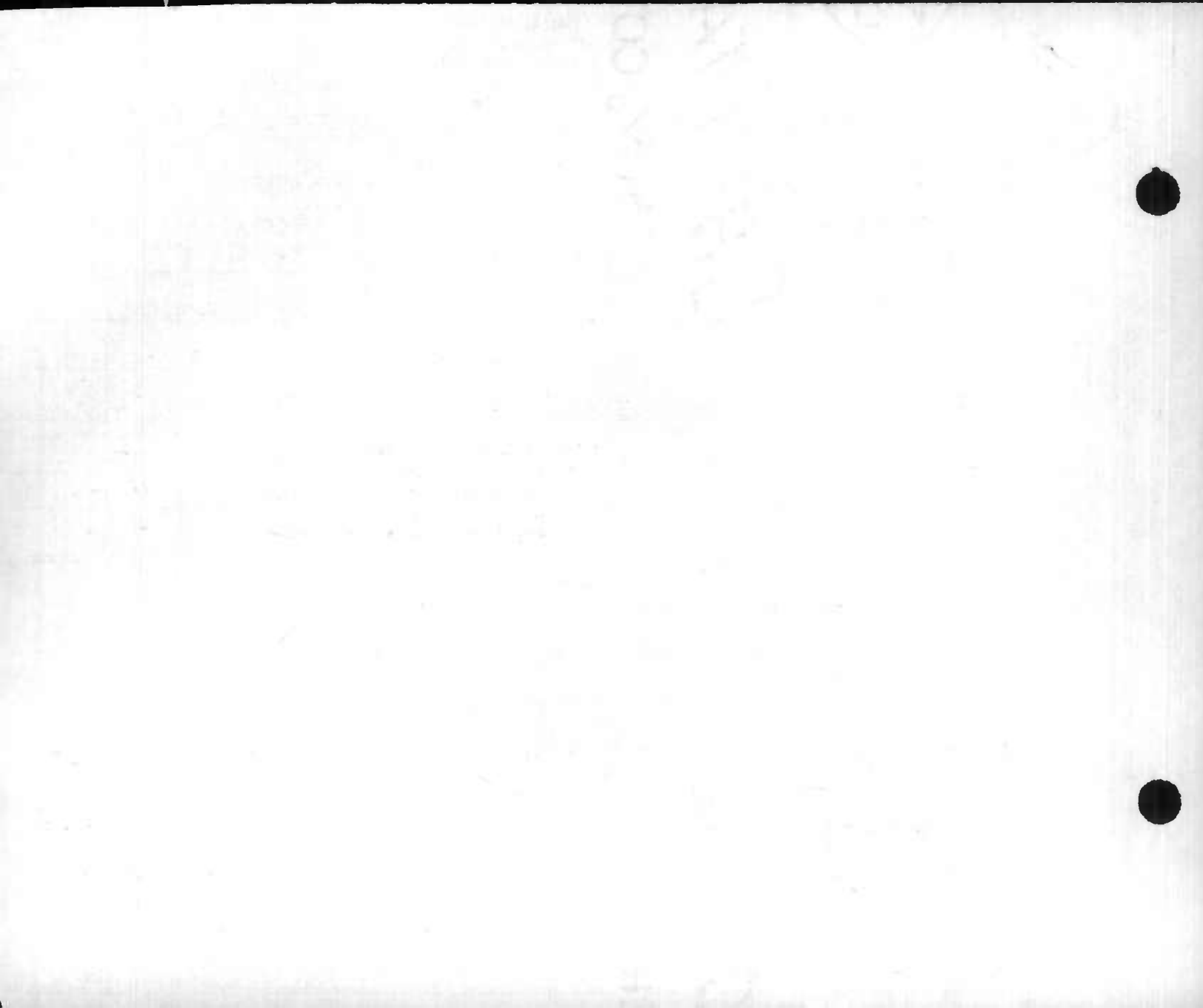
| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/2</u> , 19 <u>84</u> , to <u>02/11</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>13/15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Gregory L. Walker</u> M.D. | | DEGREE
M.D. | 22c. DATE SIGNED
02/13/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gregory L. Walker M.D. | | 22e. ADDRESS
3300 N. CALVERT STREET 21218 | |

| | | | |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | 23b. DATE
2/14/85 | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Gregory L. Walker</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 5 0 4 9 2 3

1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leatrice Joy VRPS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 20 85 | | | 2b. HOUR
531 P. M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 3 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
220 West Edgevale Road 21225 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert George | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rever | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-18-4670 | | 17. INFORMANT
Lloyd K. Urps | | | ADDRESS
Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/85 , 19 85 , to 2/20 , 19 85 , that (I) (we) lost the deceased alive on 2/20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
George J. Gonce | | | DEGREE
MD | | | 22c. DATE SIGNED
2/20/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George J. Gonce | | | 22e. ADDRESS
3001 S Hwy S | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
2/23/85 | | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Park | | 23d. LOCATION
Catonsville Balto Md | |
| 24. FUNERAL DIRECTOR
George J. Gonce | | | 4001 Ritchie Hwy Balto Md | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendell | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, knowledge injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

11

11-15-40

11-15-40

11-15-40



20% COTTON FIB

11-15-40

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gilbert M. VanSant | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 9 19 85 | | | | 2b. HOUR
M
11:11 a | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 22, 1923 | 6. AGE (IN YEARS)
LAST BIRTHDAY MONTHS DAYS HOURS MIN
61 YRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 12 19 85 | | 7d. HOUR
M
11:11 a | | 7e. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1700 Meridene Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sun Paper - Type Operator | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1700 Meridene Drive 21237 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roland G. VanSant | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Gehret | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
Sabring, Fla. 33870
Mrs. Mary Price 3208 Illinois Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margie A. Korell</i> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
2/13/85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn St. Balto., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Feb. 15, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. | | | | ADDRESS
Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

170



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504925

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James M. Vass | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 7, 1985 | | | 2b. HOUR
M
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 24 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1011 S. Hanover Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Vass | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Hunt | | 13e. STREET ADDRESS / ZIP CODE
1011 S. Hanover St. 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
237-03-3442 | | 17. INFORMANT
ADDRESS
Annie Vass 1011 S. Hanover Street | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic lung carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

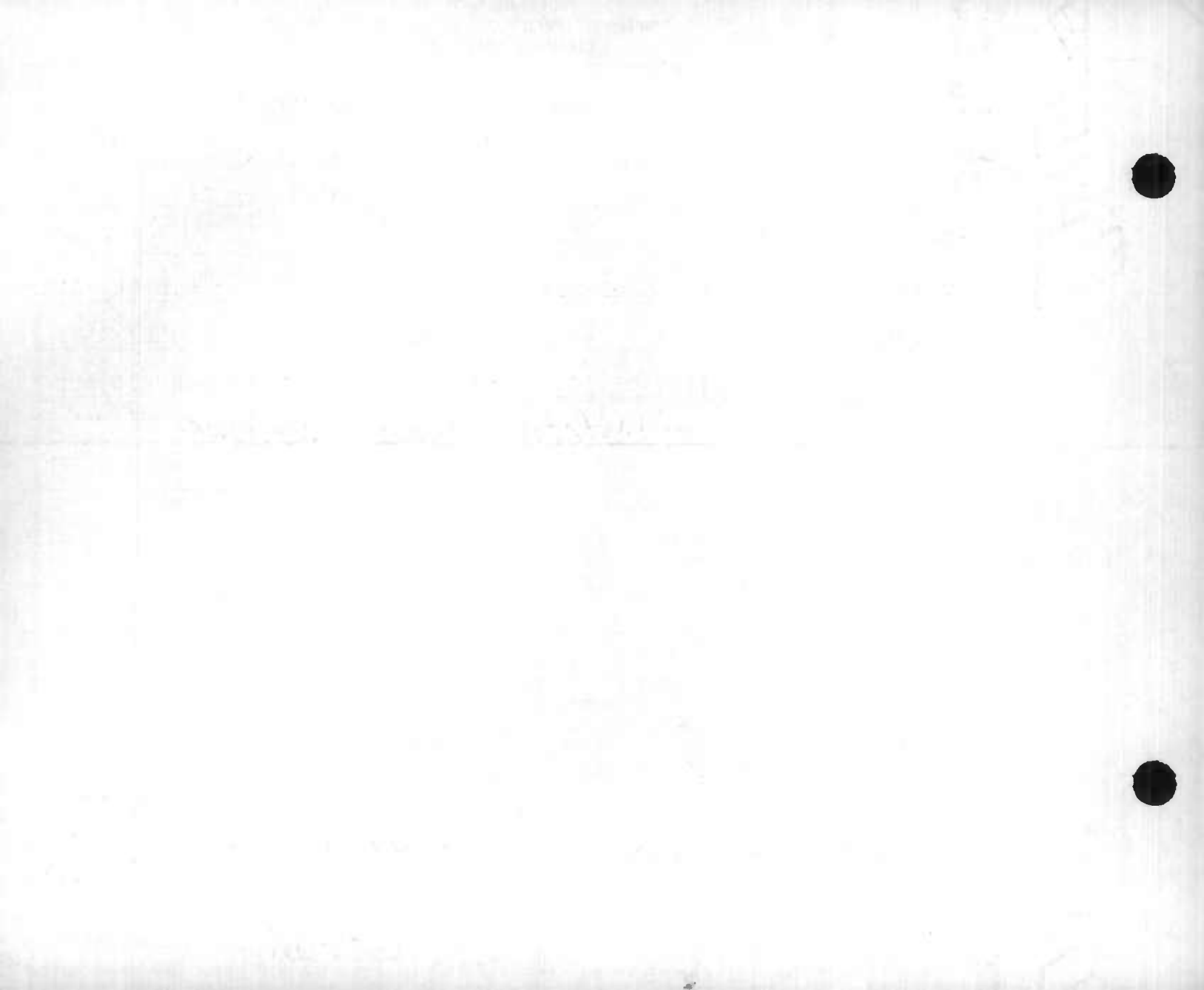
| | | | | | | | |
|--|--|---|--|--|--|----------------------------|--|
| 22b. SIGNATURE
Eric Fisher | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC FISHER | | 22e. ADDRESS
300 ARMORY PLACE, SUITE 3F, BALI, MD. | | | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(BURIAL) | | 23b. DATE
2/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. 1101 E North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | 25b. REGISTRAR'S SIGNATURE
J. W. Anderson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it is the property of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 5 0 4 9 2 6 | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALBERT ROXIE VAUGHN | | | | 2a. DATE OF DEATH (MONTH DAY YEAR) FEBRUARY 2 3 1985 | | 2b. HOUR 6 50 AM | |
| 3 SEX MALE | | 4 RACE NEGRO | | 5. DATE OF BIRTH AUG. 19 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. CITY OR TOWN BALTO 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13d. STREET ADDRESS / ZIP CODE 24 LINCOLN AVE. 21228 | | | |
| 14. FATHER'S NAME (TYPE OR PRINT) ARTIE VAUGHN | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) ELENORA HARRIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO 212-26-0652 | | 17. INFORMANT'S NAME AND ADDRESS MRS. ROBERTA B. VAUGHN 24 LINCOLN AVENUE/BALTO., Md. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) COPD, Squamous cell carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette Smoking
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, ASCVD | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22/85 , 19 85 , to 2/3 , 19 85 , that (I) (we) last saw the deceased alive on 2/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John Plavery MD | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN PLAVEY MD | | | | 22e. ADDRESS St Agnes Hospital Baltimore MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 02/07/85 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK | | 23d. LOCATION BALTIMORE BALTO., Md. | |
| 24. FUNERAL DIRECTOR MARSHALL W. JONES, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 8 1985 | | 25b. REGISTRAR'S SIGNATURE James W. Jones | |
| NAME 4101 EDMONDSON AVE./BALTO., Md. 21229 | | | | ADDRESS | | | |

BP



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170

180

190

200

210

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300

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 2 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|------------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGUERITE VINDETT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 12 1985 | | 2b. HOUR
2:00 PM | | | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 29 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
64 | | 8. UNDER 24 HRS.
HOURS MIN.
64 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MED. CEN. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT STORE | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4320 CLAREWAY 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES WOLNEY | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY O'BRIAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-68-5260 | | 17. INFORMANT
ADDRESS
DONNA THOMSON (DGHTR) 5325 SELFRIDGE AVE. 21205 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
(c) and viral syndrome | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day
several days
2 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from approx. 1980 , 19 85 , to Feb 12 , 19 85 , that (II) (we) last saw the deceased alive on JANUARY , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Sandra Walden MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2-14-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. SANDY WALDEN | | | | | | 22e. ADDRESS
JHH Brady 4 Respiration Sec. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/15/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Highview Memorial | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 24. FUNERAL HOME
Schmunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25. DATE REC'D. BY REGISTRAR
FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE
Schia Davidson-Randall | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, neurological event, or other medical condition, the medical examiner should be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1- FOR STATE REGISTRAR
AKA: Catherine Viola Turgeon | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Turgeon Catherine Viola | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/17/85 | | | 2b. HOUR
M | |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
12/21/01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA, Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
Yes | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
5536 Ashbourne Road 21227 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | | 16b. SOCIAL SECURITY NO.
218 3630 85 | | 17. INFORMANT ADDRESS
Hospital Records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>ventricular fibrillation and myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>A. Maciulis</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. MACIULIS | | | | | 22e. ADDRESS
St. Agnes Hospital Wilkens & Caton Aves. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Ambrose, Inc. 1328 Sulphur Spring Road | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>L. K. ...</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | | | | |
|--|--|---|--|---|---|--|---|-----------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LILLIAN Z. VOLKE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR FEB. 24 1985 | | | | | 2b. HOUR 9:34 P.M. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 12TH 11^{DAY} 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY at home | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS / ZIP CODE 5505 Pioneer Drive 21211 | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | | | | | | | | | |
| 4. FATHER'S NAME FIRST MIDDLE LAST John Baer | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Belle Pentz | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 264-41-1675 | | 17. INFORMANT ADDRESS Marian Pentz 3510 South River Terr. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Severe COPD | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-12 19 85 to 2-24 19 85 that (I) (we) last saw the deceased alive on 2-24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE C. Vergara-Soares M.D. | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 2-24-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. VERGARA-SOARES | | | | | 22e. ADDRESS N. CHARLES GEN. HOSP. BAY. MD. 21218 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 ^{RES.} Harford Road | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE Davidson-Pendall | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Alice S. Votta | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-12-1985 | | | 2b. HOUR
4:55 M. | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 28 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 8b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Hamilton Nursing Hm | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
unknown Gossage | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-22-8600 | | 17. INFORMANT
Catherine Holt (friend) | | | ADDRESS
3021 Chesterfield Ave. 21213 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic cancer of colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 19 <u>1933</u> , to <u>2-12</u> , 19 <u>85</u> , that (b) (we) last saw the deceased alive on <u>1-26</u> , 19 <u>85</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>George Lowe</u> | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>2-12-85</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George Lowe | | | 22e. ADDRESS
3703 Belair Rd 21213 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24 FUNERAL HOME
NAME
Schmunek Funeral Home, Inc.
ADDRESS
3331 Brehms Lane, Balto. Md. 21213 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>G. Davidson-Randall</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Barbara Wachter | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 23, 1985 | | 2b. HOUR
8:00a M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housework | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Foentsbeck | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Reisig | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-32-5432 | | 17. INFORMANT
William Lieb | | ADDRESS
610 Foxbow Dr., Belair 21014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brainstem CVA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 7 19 85 , to February 23 19 85 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 23 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Chet L. Ridley MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Ridley | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-26-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eastwood, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | | | ADDRESS
901 S. Conkling St. | | 25. DATE REC'D. BY REGISTRAR
FEB 25 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
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Index

Charles F. Fisher & Son Inc. 101 E. Franklin St.

CHIEFMAN



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Handwritten notes and a table at the bottom of the page. The table has several columns and rows of data, though the text is mostly illegible due to fading. Some visible words include "F", "H", "L", "M", "N", "O", "P", "Q", "R", "S", "T", "U", "V", "W", "X", "Y", "Z".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 3 3

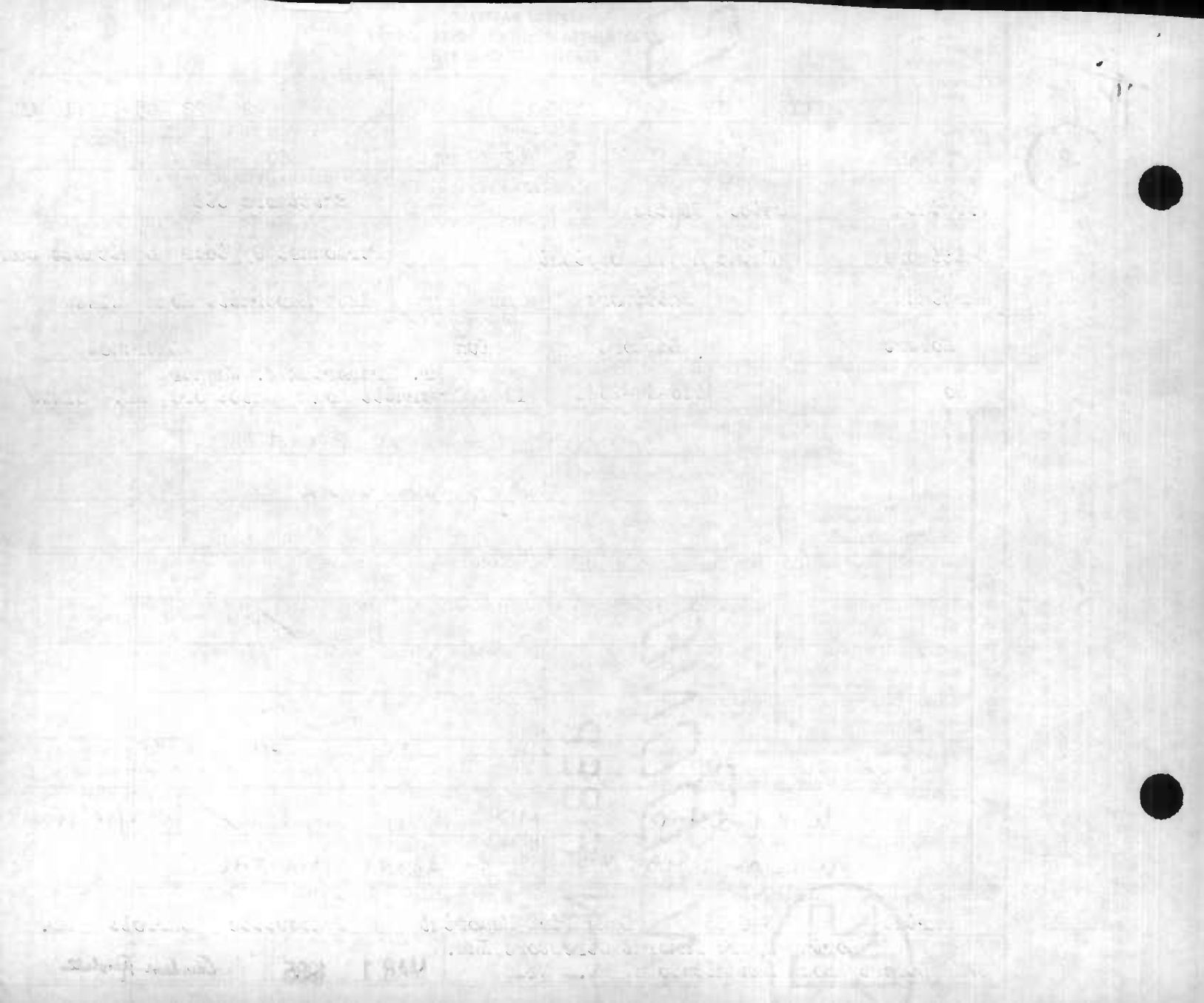
1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PHYLLIS CATHALEN WAGNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 28 85 | | 2b. HOUR
10:10 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 27 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Saint Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Personnel Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
Equitable bank | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1254 Haverhill Road 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Lawhorn | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Iva Lawrence | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
225-24-3548 | | 17. INFORMANT
Mr. Frederick J. Wagner
1254 Haverhill Road Baltimore, MD. 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) metastatic Cancer of Breast
DUE TO, OR AS A CONSEQUENCE OF
(b) Hydro pneumothorax
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11, 19 85, to 2/28, 19 85, that (I) (we) lost
saw the deceased alive on 2/28, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William L. Yap | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William L. YAP MD | | | 22e. ADDRESS
ST AGNES HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-4-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll MD. | | |
| 24. FUNERAL DIRECTOR
NAME Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

BP



A

23.00 251.1

9/18
CP
April 2nd 1944
CP
April 2nd 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LLEWELLYN B. WAKEMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEBRUARY 15, 1985 | | 2b. HOUR
PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
SEPT. 11, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6138 DUNROMING ROAD | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MECHANICAL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
MARINE | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
21239 | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
LLEWELLYN B. WAKEMAN, SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
IDA MAY DORSEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
216-05-8371 | | 17. INFORMANT ADDRESS
M. VIRGINIA WAKEMAN 6139 DUNROMING RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure, Arteriosclerotic vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 2/13 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert Weiss | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT WEISS, M.D. | | | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL 323-2200 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
FEB. 18, '85 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM E. JOHNSON | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | | |
| ADDRESS
8521 LOCH RAVEN BLVD. | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Adlay W Walker</i> | | | 7a. DATE OF DEATH MONTH DAY YEAR <i>2 9 85</i> | | 7b. HOUR <i>9:32</i> M. |
| 3. SEX <i>F</i> | RACE <i>B</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 20 06</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS. | | 8. UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John L Deaton Hosp. + Med Center</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RETIRED</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland City</i> | 13b. COUNTY <i>Baltimore</i> | 13c. CITY OR TOWN <i>Baltimore</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS - ZIP CODE <i>2206 Lynbrook Ave 21217</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Preston Waters</i> | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Pearson</i> | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>219 16 2729</i> | | 17. INFORMANT ADDRESS <i>REV. RILEY WALKER, JR. 4932 CLIFTON AVE. 21207</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis secondary to pressure ulcer</i>
DUE TO OR AS A CONSEQUENCE OF (b) <i>Demerol 25 multiple infarcts</i>
DUE TO OR AS A CONSEQUENCE OF (c) <i>Subcapital fracture left hip untreated</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>7:00 p.m.</i> 19 <i>85</i> to <i>7:00 a.m.</i> 19 <i>85</i> , that (i) (we) lost the deceased alive on <i>Feb 9</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>J.W. Reed M.D.</i> | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.W. REED</i> | | 22e. ADDRESS <i>6115 CHAS ST. BALTO. MD 21238</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | 23b. DATE <i>2/14/85</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>ARBUTUS MEMORIAL PARK</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE (BALTO.) MD.</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>LEWIS T. GWYNN</i> | | ADDRESS <i>4517 PARK HEIGHTS AVENUE</i> | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1985</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Wenderson Henderson</i> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALICE E. WALKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 11, 1985 | | 2b. HOUR
2:00 am |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
August 1 1900 | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3106 Evergreen Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3106 Evergreen Ave. 21214 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Archer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Woolford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.
216 66 9282 | 17. INFORMANT ADDRESS
Joseph M. Woolford, Towson, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery disease ? years
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerosis ? years
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 82 to Present 19 , that (I) (we) last saw the deceased alive on 2-3 months ago, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Steve Billet, MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steve Billet, MD | | 22e. ADDRESS
1247 Liberty Road, Balto., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
2/12/85 | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | 25a. DATE REC'D BY REGISTRAR
FEB 11 1985
25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1985 York Road, Baltimore, MD 21218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 3 8

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Annle Walker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 10 85 | | 2b. HOUR
11 A M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 1 1893 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
91 | | 7. YRS.
YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Indies | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DEATON Hospital & Med. Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Pvt. Family | | 13a. STREET ADDRESS / ZIP CODE
John Denton Medical Center Balto. Md. 21230 | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Simmons | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christiana Wright | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
No. | | 17. INFORMANT
Dennis Whittaker | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CNF
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD
DUE TO, OR AS A CONSEQUENCE OF (c) CBS, decubitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CBS, decubitus | | | | | | |
| 19a. DATE OF OPERATION
2 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:15 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that this hospital attended the deceased from 4/15 19 85 to 2/10 19 85 , that (we) lost the deceased alive on 2/10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
J. A. Gladu MD | | DEGREE
MD | | 22c. DATE SIGNED
2/10/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/15/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 24. FUNERAL HOME
NAME ADDRESS
Nutter & Sons 2501 Gwynns Falls Parkway
Funeral Home Inc. Baltimore, Maryland 21216 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
J. A. Gladu | | | | |

BP

John Brown
Rev. Family
John Brown
Rev. Family

John Brown

John Brown
Rev. Family
John Brown
Rev. Family

John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 3 9

1 - FOR
STATE
REGISTRAR

REG. NO.

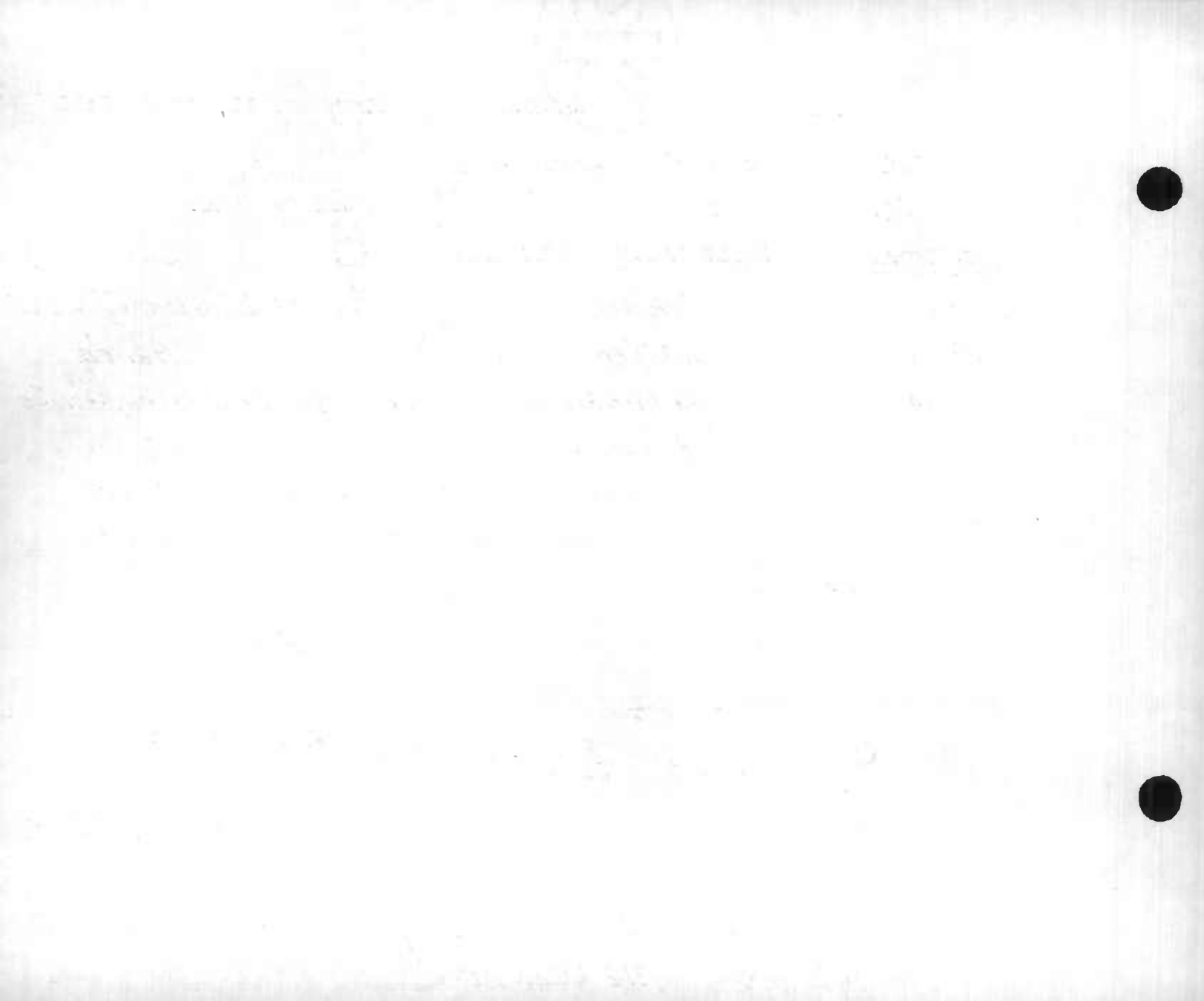
| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ARTHUR WALKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 13, 1985 | | | 2b. HOUR
3:55
P M | |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 4-1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Rigger | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Co. | |
| 13a. STATE
MD. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN - WALKER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Harris | | 16. STREET ADDRESS / ZIP CODE
916 N. WASHINGTON, SC. 21205 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-09-5313 | | 17. INFORMANT
MRS. Beulah Walker ADDRESS
916 N. WASHINGTON St 212 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 mins |
| DUE TO, OR AS A CONSEQUENCE OF
(b) ANOXIC encephalopathy | | | | | | | 3 wks |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CARDIAC ARREST | | | | | | | 3 wks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Coronary Artery Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1 19 85 to Feb 13 19 85 .
saw the deceased alive on Feb 13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles J. Duffy | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/13/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles J. Duffy | | 22e. ADDRESS
Johns Hopkins Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-18-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore City | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALT BALT MD | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Gallick | | ADDRESS
2431 E. Oliver St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Calvin</u> MIDDLE <u>James</u> LAST <u>Walker</u>
<u>Calvin James Walker</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>2</u> <u>18</u> <u>85</u> | | | | | 2b. HOUR
<u>05</u> M | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>09</u> <u>08</u> <u>28</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>56</u> YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore city</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>University Maryland Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Executive Manager</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Auto Parts</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>MD</u> | | 13b. COUNTY
<u>Ann Arundel</u> | | 13c. CITY OR TOWN
<u>Glen Burnie</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>1034 Dumbarton Rd. 21061</u> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>George F. Walker</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Maggie Alberta</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>Yes</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>WW II</u> | | 17. INFORMANT
<u>Virginia W. Walker</u> | | ADDRESS
<u>Same as 13e</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Wide metastasis, angiosarcoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>7/17/84</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>angiosarcoma</u> | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>84</u> , to <u>2-18</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ming Chang</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>2-18-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MING CHANG</u> | | | | | 22e. ADDRESS
<u>22 S. Greene St, Baltimore, MD 21205</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>2/21/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Maryland Vets Cemetery Crownsville</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>A.A. Md</u> | | | |
| 24. FUNERAL DIRECTOR
<u>George J. Gonce</u> | | | | | 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 22 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | |

BP _____



12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 04941 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EDWARD D. WALKER | | | | 2b. HOUR
4:40 PM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
11 25 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
50 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Clarence Powell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Selma | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
239-36-2391 | | 17. INFORMANT ADDRESS
Leona Walker 1923 Aisquith Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ELECTROLYTE DISTURBANCES
DUE TO, OR AS A CONSEQUENCE OF (c) Abdominal process - unknown | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
history pancreatitis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CIRCUMSTANCES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 85 , to 2/10 , 19 85 , that (I) (we) lost saw the deceased alive on 2/10 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE
David S. Dunn MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2/10/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID S. DUNN | | | | 22e. ADDRESS
201 E. UNIVERSITY PKWY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | | |



20% COTTON

BALTIMORE CITY

UNION MEDICAL HOSPITAL

BALTIMORE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 4 2

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace Betty Walker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-28-85 | | 2b. HOUR
4:30 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 31, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Tracey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lottie Bosley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-01-8098D | | 17. INFORMANT
Patrick W. Whiteman ADDRESS
6101 Loch Raven Blvd.
Baltimore, Md. 21239 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest (Intra-ventricular hemorrhage)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible aneurysm</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction / possible asphyxiation</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>myocardial infarction / possible asphyxiation</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I (this hospital) attended the deceased from <u>FEB 28</u> , 19 <u>85</u> , to <u>FEB 28</u> , 19 <u>85</u> , that (I (we) last saw the deceased alive on <u>FEB 28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Theodore Kramer</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-28-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Theodore Kramer | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar. 4, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Middletown Methodist | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Freeland Balto., Md. |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. | | ADDRESS
6500 York Rd.
Balto., Md. 21212 | | 25a. DATE REC'D. BY REGISTRAR
MAR 6 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Susan Davidson-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

1951

John J. White, Jr., Esq.

10.1

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



| FOR
1- STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 4 9 4 3
REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Walker | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 4, 1985 | | | | 2b. HOUR
P.
11:15 M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/ 29/1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Melchor Nursing Home 21218 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
coal yard worker | | 12b. KIND OF BUSINESS OR INDUSTRY
coal | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1142 Roland Heights Ave. 21211 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Al Walker | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Ushbrook | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
216-01-3204 A | | | | 17. INFORMANT
Melchor Nursing Home | | | | ADDRESS
Balto. Md. 21218
2327 N. Charles St. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-pulm arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>COPD, Abdominal mass</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>81</u> , to <u>2/4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lauren Bloh</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/5/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>L. BLOH</u> | | | | 22e. ADDRESS
<u>333 ST PAUL PL</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 11 1985 <u>John Seitz</u> | | | | | |

FORM

1888

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

DATE

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1. The following is a list of the lands which are being offered for sale under the provisions of the Act of March 3, 1879, entitled "An Act to provide for the sale of the public lands belonging to the United States, which were not disposed of by the Act of March 3, 1879, and for other purposes."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 11 per phone 2/27/85 dad

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 4 4

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROSA H. WALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/20/85 2005 | | 2b. HOUR
11:40 AM |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
10 15 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
SOUTH CAROLINA
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
R.D., | | 12b. KIND OF BUSINESS OR INDUSTRY
Nurse |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1956 W. MOSHER ST. 21217 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-14-0257 | | 17. INFORMANT
ADDRESS
JAMES A. WALLS 1946 W. MOSHER ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracerebral & intraventricular bleed</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
yes
yes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/18</u> , 19 <u>85</u> , to <u>2/20</u> , 19 <u>85</u> , that (I) have lost saw the deceased alive on <u>2/18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) have (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Michael S. Miller, MD</u> | | DEGREE | | 22c. DATE SIGNED
2/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL S. MILLER, MD. | | 22e. ADDRESS
St Agnes Hosp., 900 Caton Ave., 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
2/25/85 | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT & SON 4600 LIB. HIGHTS AV. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO.
8 5 0 4 9 4 5 | | | | | | |
|--|--|--|--|--|--|---|---|-----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CHARLES N. WARD Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 14 85 | | | | | 2b. HOUR
1:04 PM | |
| 3 SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH MONTH DAY YEAR
2 1 55 | | 6 AGE (IN YEARS LAST BIRTHDAY)
30 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE
3443 SPELMAN RD 21225 | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
CHARLES WARD | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MALCOLMA SCOTT | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | | | | | 16b. SOCIAL SECURITY NO.
219-64-9924 | | 17 INFORMANT ADDRESS
Charles N. Ward, Sr. 3443 Spelman Rd. | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hx of sarcoidosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? <u>medial BX</u>
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
<u>2nd degree</u> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/10</u> , 19 <u>85</u> , to <u>2/14</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Alfonso A Ortiz</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>2/14/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ALFONSO A. ORTIZ</u> | | | | | 22e. ADDRESS
<u>3001 S. HANOVER ST BALTIMORE MD.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Anne Arundel Co, Md. | |
| 24 FUNERAL DIRECTOR NAME
Wm C March F/H Inc. | | | | | 24b. ADDRESS
1101 e North Avenue | | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 15 1985 | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly made and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DOROTHY E. WARD | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 1985 | | | 2b. HOUR
1:40 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 24 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1902 Boone Street 21218 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard T. Ward | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Miles | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | | | 16b. SOCIAL SECURITY NO.
216-20-7219 | | 17. INFORMANT
ADDRESS
Anthony Ward 3317 Mondawmin Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) In fact of ① caduate nucleus + Frontal-temporal deg. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Atherosclerotic cardiovasc. Dz | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <u>Dr. (this hospital)</u> attended the deceased from <u>2/7</u> 19 <u>85</u> , to <u>2/18</u> 19 <u>85</u> , that <u>(I)(we)</u> lost saw the deceased alive on <u>2/18</u> 19 <u>85</u> , and that in <u>(my)(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. M. Deeth Jr. | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/18/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F.M. GLOTH M.D. | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk., Arbutus, | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

1941

WARD

DONOR

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

UNION MEMORIAL HOSPITAL

W.D. GUTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Dorothy M. Ward | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 2-20-85 | | | | | 2b. HOUR
7:15P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 12, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A/ | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Francis Scott Key Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Char Woman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Bankw | | |
| 13a. STATE
Md. | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Balto., | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
211 N. Belthord Ave. 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? --- Allgeier | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary --- ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
212-07-7596 | | 17. INFORMANT
Balto., Md. 21224.
Mrs. Marie Ernstberger-426 Imla St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ? Etiology
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Glenn Bolton | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn Bolton | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. Funeral Home
3000 E. Baltimore St., Balto., Md. 21224 | | | | | DATE REC'D. BY REGISTRAR
FEB 26 1985
REGISTRAR'S SIGNATURE
Davidson-Randell | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JEROME WASHINGTON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 1985 | | | |
| 3. SEX
m | | | | 7b. HOUR
6:01 M | | | |
| 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-23-37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | 7a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 28, 1985 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOTEL | | 12b. KIND OF BUSINESS OR INDUSTRY
2121A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHARD WASHINGTON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETTA GOTT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
217-34-8056 | | 17. INFORMANT
ADDRESS
CYNTHIA M. WASHINGTON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I, (this hospital) attended the deceased from February 27, 1985 to February 28, 1985 , that (I, (we) last saw the deceased alive on February 28, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. Roubenoff | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROUBENOFF | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-5-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson F.H. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Susan Davidson Handell | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM WASHINGTON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 02 14 85 | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 25 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT CITY | |
| 10. CITY OR TOWN OF DEATH BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAL HOSP BALT | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 3615 FORDS LA. APT 305 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Geo. Washington | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Eliza Washington | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS Sallie Washington - 3615 Fords La. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST / RESP ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) BRAINSTEM INFARCT
DUE TO, OR AS A CONSEQUENCE OF
(c) -7d | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7 , 19 85 , to 2/14 , 19 85 , that (I) (we) lost saw the deceased alive on 2/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE | | 22c. DATE SIGNED 2/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 2/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Brooklyn Md. | |
| 24. FUNERAL DIRECTOR
NAME Charles H. Powell ADDRESS 1206 W North Ave | | | | 25a. DATE REC'D. BY REGISTRAR FEB 15 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|----------------------|--|---|-------------------------------|--------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Zadie | | | FIRST MIDDLE LAST Washington | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 2-25 1985 | | | 2b. HOUR M | | |
| 3. SEX F | 4. RACE NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR 12 22 10 | 6. AGE (IN YEARS)
LAST BIRTHDAY 74 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD 2-25 1985 | | | 2d. HOUR 7:55 P. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. - N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY BALTO | | | 13c. STREET ADDRESS 1006 N. Wolfe St | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST George Williamson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Hankins | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT ADDRESS Ruth Thomas 1006 N. Wolfe St | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 2-26-85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 3/1/85 | | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem. | | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE BALTO., MD | | |
| 24. FUNERAL DIRECTOR NAME Locks Funeral Home | | | ADDRESS 1304 N. Central Ave | | | 25a. DATE REC'D. BY REGISTRAR MAR 1 1985 | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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2002 COLLECTIBLES

11/11/11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 3 and 4 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 04951 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ERNEST H WATERS JR | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 02 85 | | 2b. HOUR
4:01 PM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/29/1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66
YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balt. City Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH A CITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. med | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Balt. City 13c. CITY OR TOWN Balt. City | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE
201 N. Broadway 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest H Waters | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Waters | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
213-12-3719 | | | |
| 17. INFORMANT
NAME ADDRESS
Mary Waters 5220 York & Z. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Bacterial sepsis & acidosis
DUE TO, OR AS A CONSEQUENCE OF (c) Lung Cancer
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes / 1 day | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Lung Cancer | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2/2 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N. Wolfe St. Balt. MD | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/2 19 85 to 2/2 19 85 , that (1) (we) last saw the deceased alive on 2/2 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | |
| 22b. SIGNATURE
Kevin J. Twohig | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/2/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kevin J. Twohig | | 22e. ADDRESS
N. Wolfe St. Balt. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
2/6/85 | | 23b. DATE
2/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Living Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balt. County Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Carl 1712 W. North | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

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CHICAGO
LIBRARY
DIVISION OF THE PHYSICAL SCIENCES
540 EAST 58TH STREET
CHICAGO, ILL. 60637

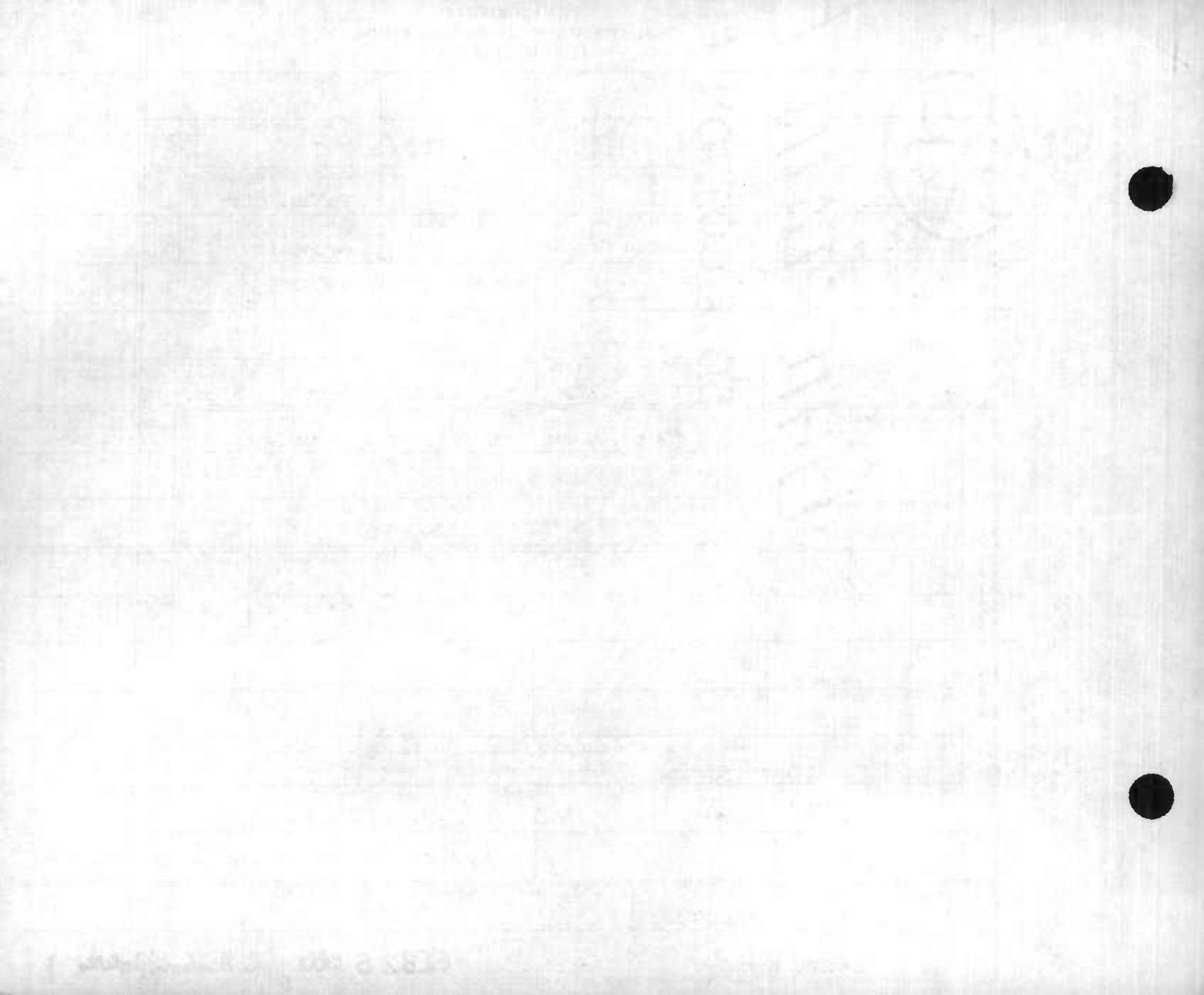
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

| 1- STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 4 9 5 2 | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| WILLIAM WATERS | | | | 2 9 85 | | | | M | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 22 02 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Bakery | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
607 Pa. Ave. 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Waters | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
218-01-8773 | | 17. INFORMANT ADDRESS
Ms. Rosalyn Howard 2515 Woodbrook Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA of BLADDER (URINARY BLADDER)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Many years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>CVA, CHF</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-12-1972</u> to <u>2-9-1985</u> , that (I) (we) last saw the deceased alive on <u>2-9-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Samuel Waters</u> | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-19-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. Y. KHAN | | | | 22e. ADDRESS
1528 KING WILLIAM DRIVE, BALTO, MD 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | | | 4. RACE | | | |
| Johana Rose Waudby | | Female | | | | White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 01-24-1966 | | 69 YRS | | | | Baltimore City MD. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Mercy Hospital | | | | Homemaker | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | | | Balto | | | | 17 S. Tanney St. Balto, MD 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | |
| Vaclav Zeman | | Anna Kosar | | No | | | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| 219.38.9840 | | John J. Waudby (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>respiratory failure</u> | | | | | | | | | hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>end-stage chronic obstructive pulmonary disease</u> | | | | | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>prob. pneumonia</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>prob. pneumonia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/8/85</u> to <u>2/20/85</u> , that (I) (we) last saw the deceased alive on <u>2/20/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body, after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE <u>K. Robie - Suh MD</u> | | | | DEGREE | | | | 22c. DATE SIGNED <u>2/20/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| K. Robie - Suh MD | | | | Univ. of Md. Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 2/23/1985 | | Oak Lawn Cemetery | | Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Walter Brooks Bradley, Inc. Balto., MD 21222 | | | | FEB 21 1985 | | Julia Davidson-Randall | | | |

20% COTTON LIME

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <i>Nelson</i> MIDDLE <i>Eddie</i> LAST <i>Weaver</i>
<i>Nelson Eddie Weaver</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>2 28 85</i> | | 2b. HOUR
<i>435 PM</i> | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 4 41</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>44</i> | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Machine Operat.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Box Factory</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>---</i> | 13c. CITY OR TOWN
<i>Baltimore</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Walter Weaver</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Idessa Blair</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>217-38-1943</i> | | 17. INFORMANT ADDRESS
<i>Betty L. Weaver 216 N. Luzerne Ave. 21224</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>EXSANGUINATION 2° Erosion of Tumor</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Wld PULM. ARTERY.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>SQUAMOUS CELL CA OF LUNG</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>---</i> | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 84</i> 19 <i>84</i> , to <i>Feb 28</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Feb 28</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Edward J. Britton</i> DEGREE <i>MD</i> | | | | 22c. DATE SIGNED
<i>2/28/85</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>E J BRITTON MD</i> | | | | 22e. ADDRESS
<i>FRANCIS SCOTT KEY MED CTR BALTO MD</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3-4-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Eastwood Balto. Co., Md.</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Charles S. Zeiler & Son Inc. 901 S. Conkling St</i> | | | | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE
<i>MAR 04 1985</i> <i>John H. Anderson</i> | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 5 5

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Waverly Weaver | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 9, 1985 | | | 2b. HOUR
11:25am | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 16 52 c | | 6. AGE (IN YEARS LAST BIRTHDAY)
32 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
641 W. Pitcher St. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Weaver | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Nel Rikken | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
218-60-4509 | | 17. INFORMANT ADDRESS
Pauline McCormick 2542 Cecil Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Colon Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11:25 am
2/9/85 | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 20 , 19 85 , to February 9 , 19 85 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 9 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (do) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert J. Chapolini</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2/9/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Chapolini | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H Inc. 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

1

QWED

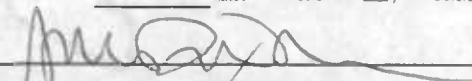
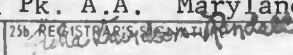
REBIL

WIND



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

| FOR
1- STATE REGISTRAR | | | | | | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Joseph Wayne Webb | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED
MONTH DAY YEAR
2 27 1985 | | | | | | | | | | 2b. HOUR
M
6:45 a M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 19 84 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
6 | | IF UNDER 1 YR.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 27 1985 | | 2d. HOUR
M
6:45 a M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2138 Wilkens Avenue, 21223 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Billy W. Webb Jr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carol Ann Humphrey | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N/A | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | | | 17. INFORMANT
ADDRESS
Billy W. Webb, Jr. 2138 Wilkens Avenue 21223 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2/27/85 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | | | | | | | ADDRESS
111 Penn St. Balto, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
03-01-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk. A.A. Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | | | | | | | | | ADDRESS
21229 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |

NOV 19 1961

WILLIAM W. DOWD



Released by Dr. Gregory Lee to Rev. 2-6-85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7-10000 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504957

| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| FIRST MIDDLE LAST
Frances Dolores Weber | | | | MONTH DAY YEAR
February 6 1985 | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | |
| Female | | White | | MONTH DAY YEAR
November 5 1913 | | | | 71 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 404 S. Madeira St. | | | | Housewife | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 404 S. Madeira St. 21231 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST
George - Hitchens | | | | FIRST MIDDLE LAST
Mary Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | |
| NO --- | | | | 213 28 5730 | | | | 21229
Geraldine Vonella 3726 Clarendell Rd | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-9-83</u> to <u>9-9-83</u> , that (I) (we) lost above the deceased <u>above</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. R. N. Niznik</u> | | | | DEGREE | | | | 22c. DATE SIGNED
<u>2-6-85</u> | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>T. S. NIZNIK</u> | | | | 22f. ADDRESS
<u>429 S. Chester St</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Feb. 9 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | | | 25b. REGISTRAR'S SIGNATURE
<u>J. W. Anderson</u> | | | | | |

BP

U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF

1

[Faint, illegible handwritten text on lined paper]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 5 8

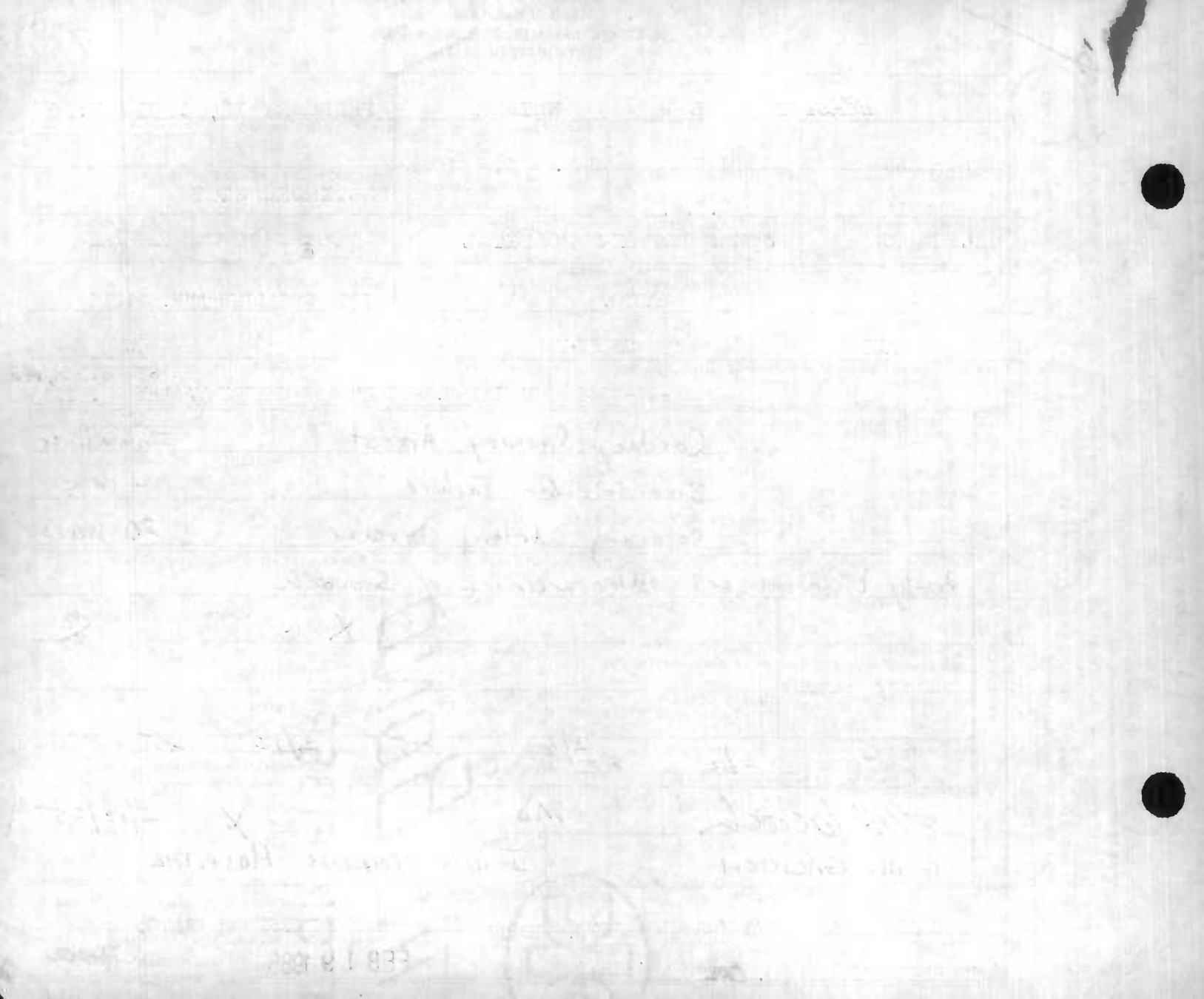
FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DOROTHY LEE WEINER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 12, 1985 | | 2b. HOUR
7:50 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN. 1, 1900 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DANIEL SELIGMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATIE UNKNOWN | | 16. STREET ADDRESS / ZIP CODE
3016 ROSALIND AVE. 21215 | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
219-01-8348 | | 17. INFORMANT
ADDRESS
DANIEL S. WEINER 109 CHERRY VALLEY RD. 21136 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Biventricular Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Artery Disease | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immediate
2 days
20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Poorly Differentiated Adenocarcinoma of Stomach | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (1) (this hospital) attended the deceased from 2/6 , 19 85 , to 2/12 , 19 85 , that (we) lost
saw the deceased alive on 2/12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
G.M. GACIOCH | | DEGREE
MD | | 22c. DATE SIGNED
2/12/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G.M. GACIOCH | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/14/85 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. HEBREW CEM | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
REISTERSTOWN BALTO. MD | | 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS. INC. | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
6010 REISTERSTOWN RD. BALTO. MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | | | |
| 25b. REGISTRAR'S SIGNATURE
a Davidson-Randall | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504959

1. FOR
STATE
REGISTRAR

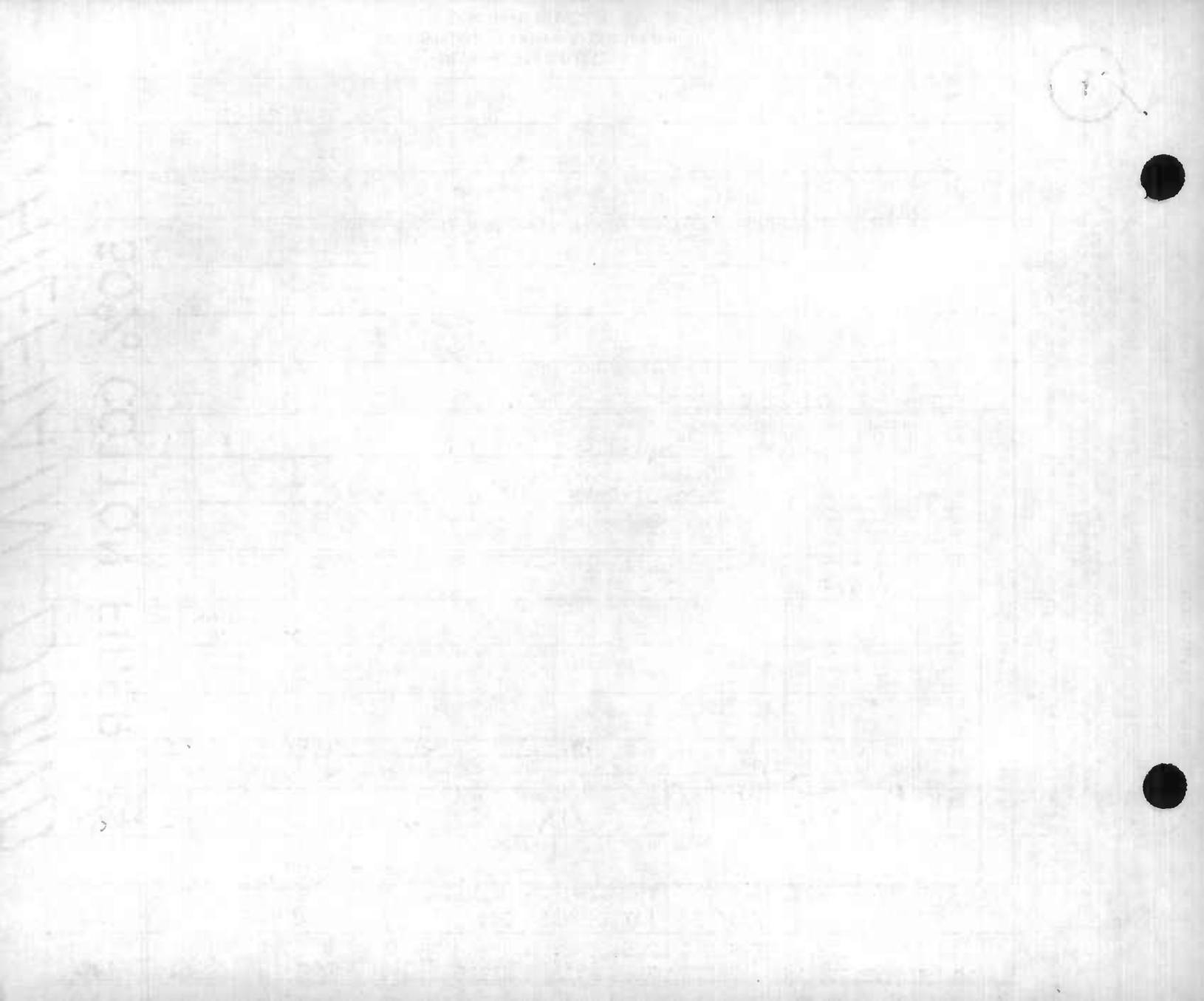
REG. NO.

| | | | | | | | | |
|--|---|---|--|--|--|--|-----------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| SIMON B. WEINER | | | FEBRUARY 21, 1985 | | | 6 A. M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| MALE | WHITE | JUNE 21, 1921 | 63 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | 6307 SHELICK DR. 21209 | | | EXECUTIVE | | | IMPORTER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MARYLAND | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6307 SHELICK DR. 21209 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| PHILIP WEINER | | | ANNIE WEINER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| YES | | | WWII-ARMY | | | MRS. ESTHER WEINER 6307 SHELICK DR. 21209 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | <u>Immediate</u> |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial infarction</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| <u>None</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-19-85</u> to <u>2-21-85</u> , that (I) (we) last
saw the deceased alive on <u>2-19-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body of the deceased. | | | | | | | | |
| 22b. SIGNATURE
<u>Michael T. Rudikoff</u> | | | DEGREE
<u>MD</u> | | | 22c. DATE SIGNED
<u>2-21-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| DR. MICHAEL T. RUDIKOFF | | | 222 W. COLDSRING AVE. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| BURIAL | | | 2/24/85 | | | AITZ CHAIM CEM | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| SOL LEVINSON & BROS., INC. | | | FEB 27 1985 | | | <u>Eric Davidson-Randell</u> | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | 7a. DATE OF DEATH MONTH DAY YEAR | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOHN E. WEITZ | | | | | | 28 85 | | | | | | 2 40 AM | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
11 3 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Luthersan Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UPHOLSTER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1433 WALKER AVE. 21239 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WEITZ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELISE RUEBECK | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
UNK | | | | 16b. SOCIAL SECURITY NO.
220 07 3934 | | 17. INFORMANT ADDRESS
LOIS KMIEC 1433 WALKER | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHRONIC RESPIRATORY DISEASE
DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
L. CUETO | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/8/85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. CUETO | | | | 22e. ADDRESS
LUTHERSAN HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME
J.G. CONNELLY | | | | | | ADDRESS
300 MACE | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Frederick R. Riddle | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

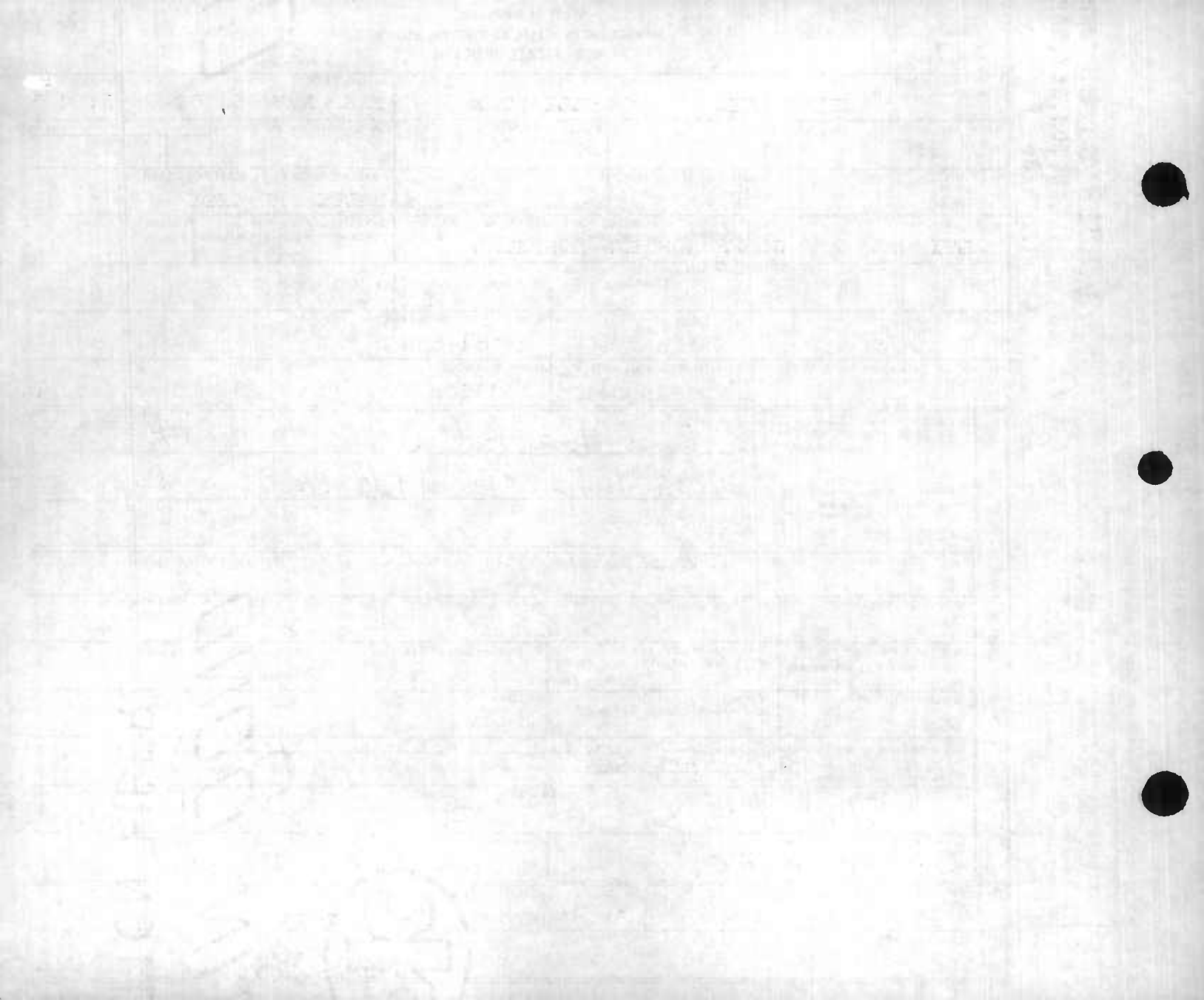
8504961

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
(BEY) MARGIE WELLINGTON BEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1985 | | 2b. HOUR
5:00
A M | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48
YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Banks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-50-4186 | | 17. INFORMANT
ADDRESS
Lillian B. Smith 4619 Northwood Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Metastatic Renal Cell Ca
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5-17
1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 85 , to 2/15 , 19 85 , that (I) (we) last saw the deceased alive on 2/15 5 AM , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward Kasper | | DEGREE
MD | | 22c. DATE SIGNED
2/15/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD KASPER | | 22e. ADDRESS
Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H | | ADDRESS
1101 E. North Ave. | | 25b. REGISTRAR'S SIGNATURE
FEB 19 1985 Julia Barden-Randall | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04962

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Edward F. Welsh | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 14 / 85 | | | | 2b. HOUR
5:50 AM | |
| SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired U.S. Government | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10 E. Chase St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Welsh | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Kinney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 11 | | 17. INFORMANT
ADDRESS
Joe Couto 9505 Westwood Dr. Ellicott City 21043 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic lymphocytic leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 85 , to 2/14 , 19 85 , that (I) (we) last saw the deceased alive on 2/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alan M. Blaker | | | | DEGREE
MD | | | | 22c. DATE SIGNED
2/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan M. Blaker | | | | 22e. ADDRESS
Mercy Hospital Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb 16'85 | | 23c. NAME OF CEMETERY OR CREMATORY
St Agnes Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Menands New York | | | |
| 24. FUNERAL DIRECTOR
NAME
Harry H. Witzke 4112 Columbia Rd Ellicott City | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 14 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

DAVEY LAW



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 6 3

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLOTTE WENDLING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 18, 1985 | | 2b. HOUR
M
M |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
April 20, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lineworker | 12b. KIND OF BUSINESS OR INDUSTRY
Distillery | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Lithium | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Helwig | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Lesner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO
214-01-2687 | | 17. INFORMANT
ADDRESS
Mr. George Wendling 563 Sarah Avenue 21090 | |
| 18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF Electrolyte Imbalance
(b) CD PD + A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF Heart
(c) Heart
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. E.M. Ramos, M.D. | | DEGREE
MD | | 22c. DATE SIGNED
February 20, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
Parkana Medical Center Baltimore Highlands | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/21/85 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ambrose Funeral Home 1328 Sulphur Spring Rd. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
John T. ... |

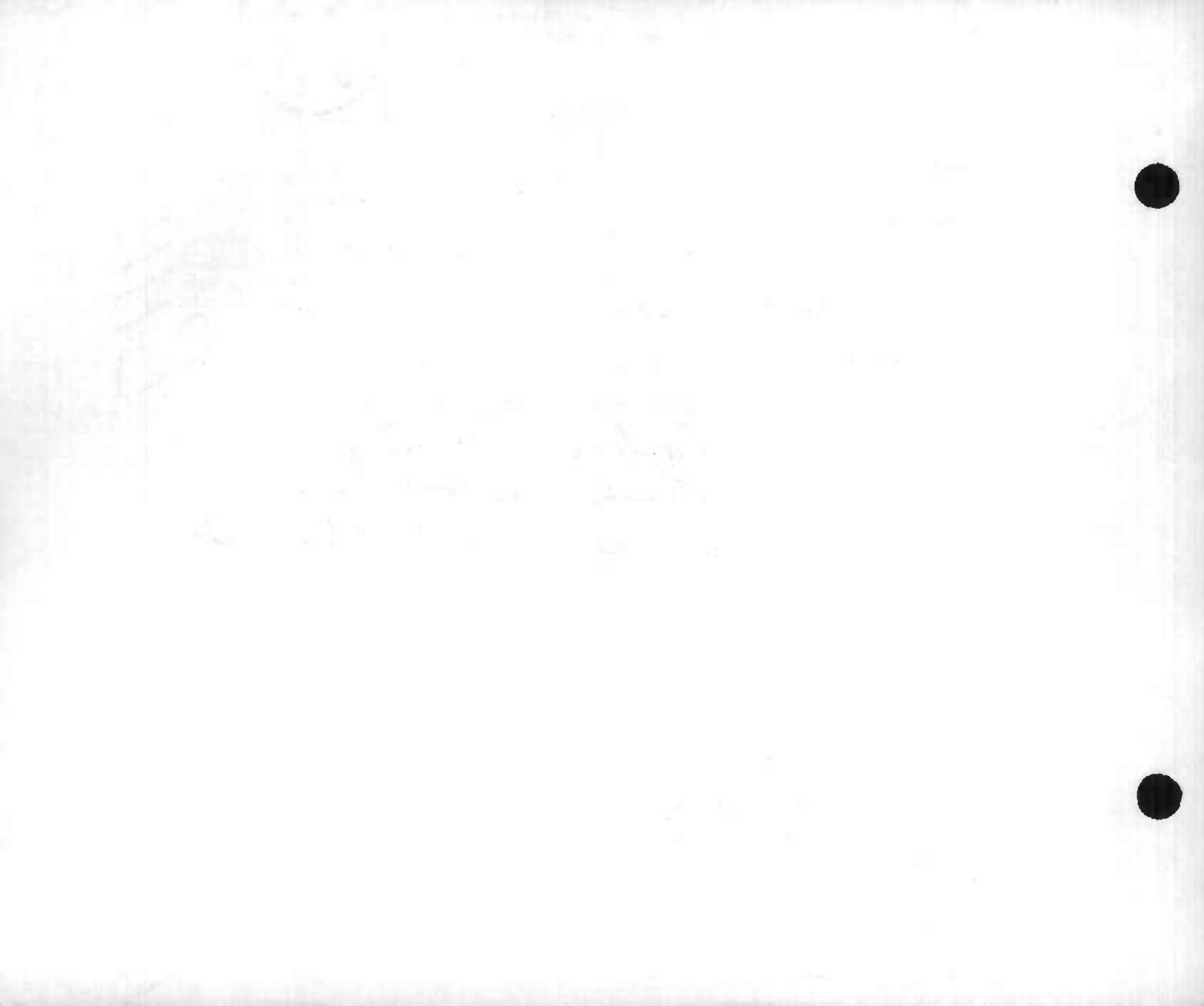
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
John Wenter | | | | | 2a DATE OF DEATH MONTH DAY YEAR
2 18 85 | | | 2b HOUR
4 P.M. | |
| 3 SEX
Male | | 4 RACE
Cau | | 5 DATE OF BIRTH MONTH DAY YEAR
8 28 12 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hungary | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Frances Scott Key Medical Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Davison (Chemical Co.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE
Maryland | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3709 10th. St. Balto. Md. 21225 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Michael Wenter | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Kiss | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | 16b SOCIAL SECURITY NO.
236-03-5491 | | 17 INFORMANT ADDRESS
John S. Wenter, Unknown | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Resp. Failure
DUE TO, OR AS A CONSEQUENCE OF (b) COPD
DUE TO, OR AS A CONSEQUENCE OF (c) Terminal Stage Pneumoconiosis & Fibrosis | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1-22-85, 19 to 2-18-85, 19, that (I) (we) lost saw the deceased give on 2-18-85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
M. W. Hawke | | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED
2-19-85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
M. W. HAWKE | | | | | 22e ADDRESS | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
Feb. 21, 1985 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24 FUNERAL DIRECTOR
NAME
McCully Funeral Home, Mt. & Tickneck Rds. Pasadena | | | | | ADDRESS
Md 21122 | | 25a DATE REC'D. BY REGISTRAR
FEB 25 1985 | | |
| | | | | | 25b REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | |

NOV 10 1964

MINIATURE

RECEIVED NOV 10 1964

8 10 11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04965

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HARRY WEST | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-15-85 | | 2b. HOUR
8:47 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 10 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Snow Hill, Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore 21224 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Butcher | | 12b. KIND OF BUSINESS OR INDUSTRY
Meat Co. |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William T. West | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katie Orvie | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
No | |
| 17. SOCIAL SECURITY NO.
213 05 2354 | | 18. INFORMANT
Joyce West | | 19. ADDRESS
7946 St. Monica Dr.
Balto., Md. 21222 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**15 MINUTES**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **ATHEROSCLEROTIC CVA****4 WEEKS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **? 14% TBSA BURN****4 WEEKS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

PARKINSON'S DISEASE

19a. DATE OF OPERATION

2/7/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

3rd DEGREE BURNS

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. **1 16 1985**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

PT. BURNED SELF COOKING SPAGHETTI

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
HOME

21f. LOCATION

7613 Poplar Ave. Balto.

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (his hospital) attended the deceased from **1/16** **85** to **2/15** **85**, that (I) (we) lost
saw the deceased alive on **2/15** **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

JRC

DEGREE

ATTENDING MEDICAL STAFF
PHYSICIAN ☐ DIRECTOR ☐ PHYSICIAN ☒

22c. DATE SIGNED

2/15

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

JOHN R. CASSIDY

22e. ADDRESS

DEPT SURGERY JOHNS HOPKINS

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

2/18/85

23c. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

23d. LOCATION

Baltimore Co., Md.

CITY OR TOWN

COUNTY

STATE

24. FUNERAL HOME

Medzinski Funeral Home PA 1407 Old Eastern Ave

25a. DATE REC'D. BY REGISTRAR

FEB 20 1985

25b. REGISTRAR'S SIGNATURE

J. H. HOPKINS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

STANDARD SAMPLE TO WHICH REFERENCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--------------------------------------|---|--|--|--|--|--|
| <div style="text-align: right;">REG. NO.</div> <div style="text-align: center;">FOR
1. STATE
REGISTRAR</div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
ANNA C WHEALTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 16, 1985 | | 2b. HOUR
8:33 PM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/5/09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | <div>IF UNDER 1 YEAR</div> <div>IF UNDER 72 HRS.</div> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HSWE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM ENGELBERTH I | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MATILDA SHUSTER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
UNK | | 17. INFORMANT
ADDRESS
BERNARD POTTS 1207 COURT SQ. BLDG | | | | | |
| <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) _____ HYOXIA</div> <div>DUETO, OR AS A CONSEQUENCE OF _____ ASPIRATION PNEUMONIA</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____</div> <div>DUETO, OR AS A CONSEQUENCE OF _____ (c) _____</div> | | | | | | | | | |
| <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:</div> <div>HYPERTENSION HEART DISEASE S/P Breast Cancer Hypothyroid Failure Renal Failure</div> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 16, 1985, to February 16, 1985, that (I) (we) lost the deceased alive on February 16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | 22c. DATE SIGNED
2/16/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ST THOMAS G. A. H. N. | | | | 22e. ADDRESS
CHURCH HOSPITAL 21231
100 N. Broadway Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/20/85 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELLY | | | | ADDRESS
300 MACE | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

1
7

W 10/2/9

BRAND CITY

W 10/2/9

12th

CHURCH H-2

WHITE

W 10/2/9

CHURCH H-2

WHITE

CHURCH H-2

WHITE

CHURCH H-2

WHITE

10/2/9

10/2/9

10/2/9

10/2/9

10/2/9



10/2/9

10/2/9

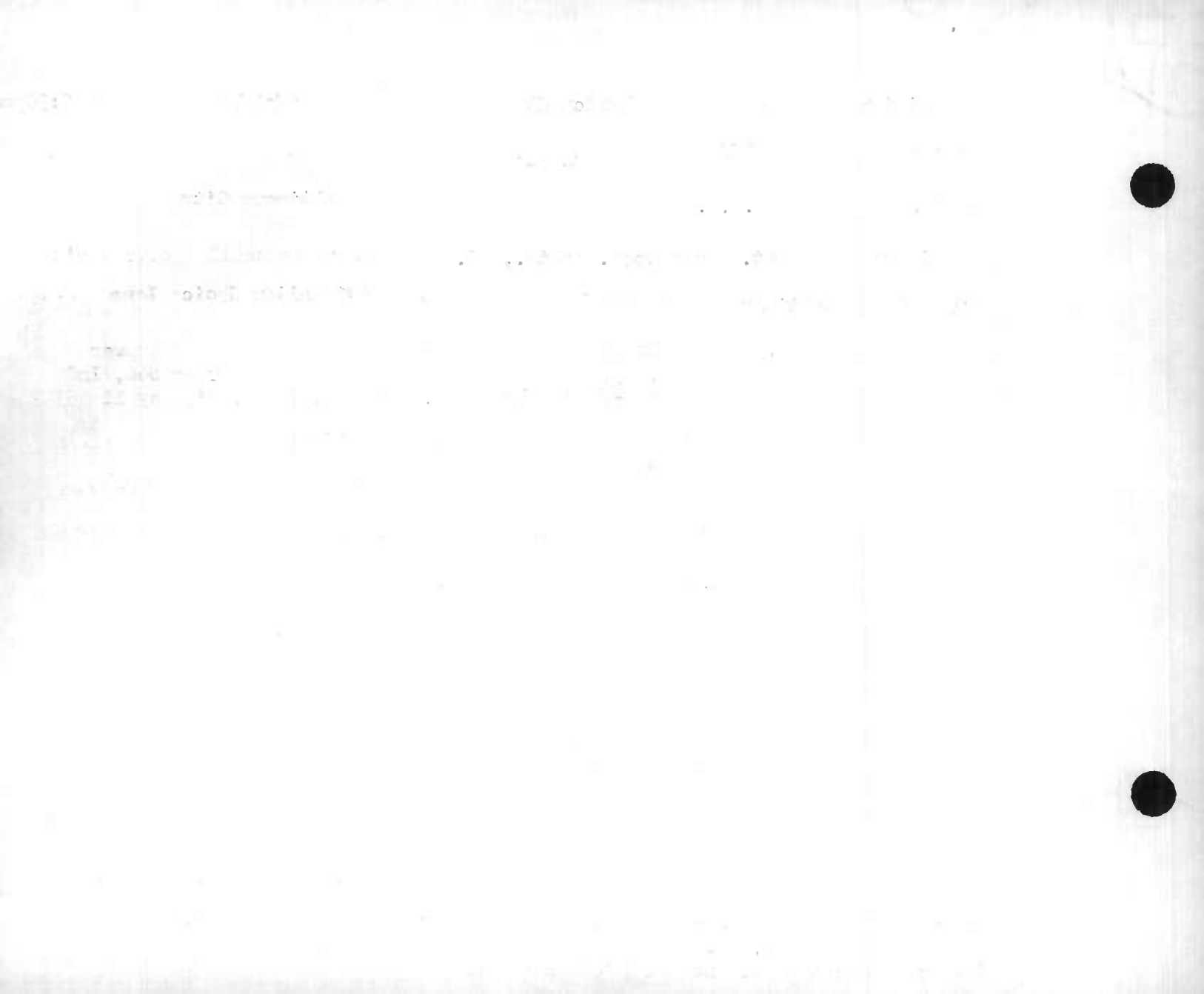
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504967

| | | | |
|---|--|--|--|
| FOR
1 - STATE
REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME
FIRST MIDDLE LAST
Vivian Tracy Wheatcraft | | | 2a DATE OF DEATH
MONTH DAY YEAR
2/14/85 |
| 3 SEX
Female | | | 2b HOUR
3:30pm |
| 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
7-27-1889 | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hosp. Balto., Md. | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Deputy Marshall | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | |
| 13c CITY OR TOWN
Catonsville | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e STREET ADDRESS / ZIP CODE
601 Maiden Choice Lane 21228 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Louis F. Tracy | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Brewer | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
577-48-6049 | |
| 17 INFORMANT
Isalle T. Reichart | | ADDRESS
Greenwood, Ind. 510 S. Highway 31 46142 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL PNEUMONIA | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD, or, Brain syndrome | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Huntington's chorea, seizure disorder | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/13 , 19 85 , to 2/14 , 19 85 , that (I) (we) last saw the deceased alive on 2/14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
M. Maciulis | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
M. MACIULIS | | 22e ADDRESS
St. Agnes Hospital, 900 S. Caton Ave. | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal/Burial | | 23b DATE
02-19-85 | |
| 23c NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Greenwood Johnson Indiana | |
| 24 FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | 25a DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| 25b REGISTRAR'S SIGNATURE
Jane Warden-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 04988 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Bertha Wheeler | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Feb 2, 1985 | | | 2b. HOUR
1:30 AM | | |
| 3. SEX
F | | 4. RACE
N | | 5. DATE OF BIRTH MONTH DAY YEAR
9 9 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | | | 13b. COUNTY
BALD | | 13c. CITY OR TOWN
BALD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Arthur Hilary | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
217-24-2549 | | 17. INFORMANT ADDRESS
Lorraine Wheeler - same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Pulmonary Embolism
DUE TO, OR AS A CONSEQUENCE OF (b) Migrating thrombophlebitis
DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension / Breast cancer metastatic shock / CPA arrest septic
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Above | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1985, 19 to Feb 2, 1985, that (I) (we) last saw the deceased alive on Feb 2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
M. E. Rodriguez MD | | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/2/1985 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mona E. Rodriguez MD | | | | | 22e. ADDRESS
3001 S. Parover St Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Law Funeral Home 4611 Park Heights Ave. 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1985 | | 25b. REGISTRAR'S SIGNATURE
M. E. Rodriguez | | | |



POST OFFICE

CHATELAIN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| MARGARET WHEELER | | | | | | February 3 '85 | | | | 12:34 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | |
| Female | | white | | 3 20 1916 | | 68 YRS. | | | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington DC. | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | FRANCIS SCOT KEY HOSP. | | | Housewife | | | Household | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | | | |
| 13a. STATE CITY COUNTY | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4944 BEACH ST. 2014 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| CARVE | | | MUMMICHUYSEN | | | MARGARET CENA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | 577-142824 | | | MARGARET M. NIEMAN SHADY SIDE MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | 45 min | |
| 8903 DUE TO, OR AS A CONSEQUENCE OF (b) RECENT MI | | | | | | | | | | 1 WEEK | |
| DUE TO, OR AS A CONSEQUENCE OF (c) BURNS | | | | | | | | | | 13 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | SMOKING IN BED 2ND & 3RD DEGREE BURNS | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | HOME | | 4944 BEACH ST SHADY SIDE MD | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20 19 85 to 2/3 19 85, that (I) (we) last saw the deceased alive on 2/3 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| David Johnson | | | | MD | | | | 2/3/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| DAVID JOHNSON | | | | FRANCIS SCOT KEY BURN UNIT BALT | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Cremation | | | 2-6-85 | | Westview | | | BALTIMORE COUNTY MD. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| T. A. Hagedorn | | | | | | FEB 4 1985 | | | K. Rindler-Randell | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REPRODUCED FROM THE NATIONAL ARCHIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 7 0

REG. NO.

| | | | | | |
|---|---|--|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Capie White | | 2a. DATE OF DEATH MONTH DAY YEAR 2/20/85 | | 2b. HOUR 1 P.M. | |
| 1. SEX F Female | 4. RACE W White | 5. DATE OF BIRTH MONTH DAY YEAR 2/14/89 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (COUNTRY) Georgia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Belts | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason F. Lord | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joshua A. Spears | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia S. Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 196-16-8836 | | 17. INFORMANT ADDRESS Ruby E. White Same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dementia, COPD, Diverticulitis, D J D, Hip Fr. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 19 83 to 2/20 19 85 , that (I) (we) last saw the deceased alive on 2/20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Susan Denman M.D. | | DEGREE | | 22c. DATE SIGNED 2/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Denman | | 22e. ADDRESS 5200 EASTERN AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/24/1985 | | 23c. NAME OF CEMETERY OR CREMATORY Tillison Cemetery | |
| 23d. LOCATION CITY OR TOWN Gagsden COUNTY Alabama STATE | | 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | |
| 25a. DATE REC'D. BY REGISTRAR MAR 11 1985 | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | |

BP

WINTER 1900

SECTION 2008 COLLECTOR

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Section 2008

Section 2008

B

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85

0497

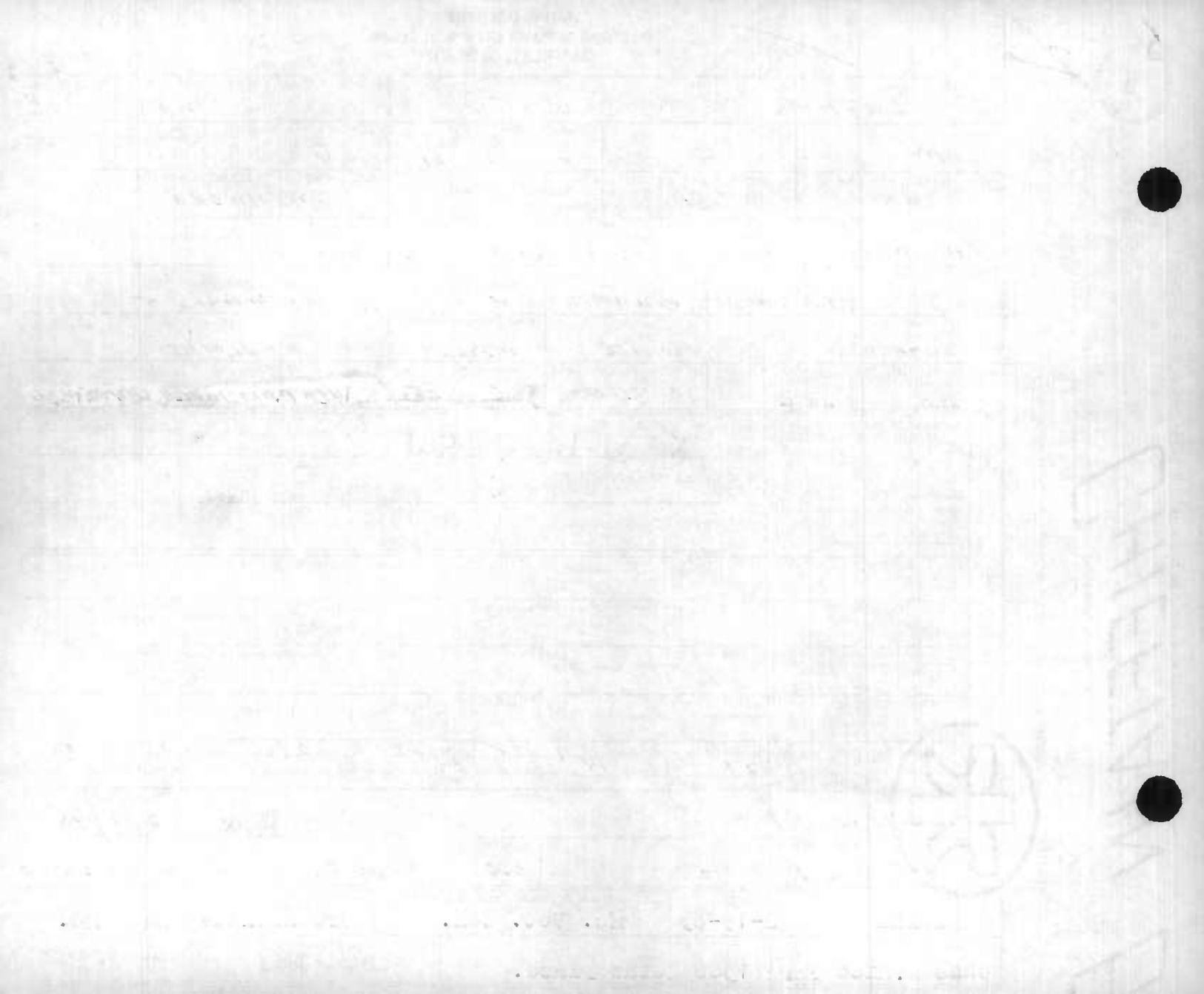
| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LUTHER WHITE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 85 | | | 2b. HOUR
3:41 P | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 22 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
63 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
123 W. HAMBURG ST 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LUTHER WHITE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MUSLEY FANNIE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
Jannie White | | 17b. ADDRESS
123 W. Hamburg St 21230 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/18 , 19 85 , to 2/11 , 19 85 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 2/11 , 19 85 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Alfonso A. Buttz | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/11/85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALFONSO A. Buttz | | | 22e. ADDRESS
3001 S. HANOVER ST BALTIMORE MD 21220 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-19-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Vet. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville AA Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Chas A. Rice FSPA | | | ADDRESS
1300 Eutaw Place. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson Handell | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 7 2

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE FLORENCE LAST WHITE
<i>MARY FLORENCE WHITE</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>Feb 18 85</i> | | 2b. HOUR
1:00 P.M. |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 28 27</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>57</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
IF UNDER 72 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ST. AGNES HOSPITAL</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>PIECE WORKER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>HAT FACTORY</i> |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>W</i> | 13c. CITY OR TOWN
<i>BALTIMORE</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>HENRY B. KAUFMAN</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>CAROLINE ADAMS</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>220-20-0312</i> | | 17. INFORMANT
ADDRESS
<i>ORVILLE R. WHITE, SR. 313 S. STRICKER ST. 21223</i> | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Lymphomatous meningitis</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 days</i> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>diffuse histiocytic lymphoma</i> | | <i>6 months</i> |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | |

| | | | |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Diabetes mellitus</i> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 15</i> , 19 <i>85</i> , to <i>Feb 18</i> , 19 <i>85</i> , that if (we) lost saw the deceased alive on <i>Feb 18</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Paul E. Gormley</i> | | DEGREE
<i>MD</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<i>2/18/85</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Paul E. Gormley</i> | | 22e. ADDRESS
<i>900 CHASE AVE BALTO. MD 21229</i> | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | 23b. DATE
<i>02-22-85</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>GARDENS OF FAITH</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>PARKVILLE BALTIMORE MARYLAND</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 22 1985</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | |

BP.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

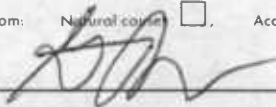
Film G601 Items 1, 14, 15

1- FOR
STATE 3/21/85 rja
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

04973

| | | | | | | | | | | |
|--|-------------------------|---|---|---|---|---|---|-----------------------------------|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Wayne Howard Whitlock | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 ? 1984 | | | 2b. HOUR M | | | | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR 10 6 52 | 6. AGE (IN YEARS LAST BIRTHDAY)
32 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 19 85 | | | 2d. HOUR
4:35 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
800 N. Hilton Pkwy | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
00000 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Craig B. Whitlock | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Mae Whitlock | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 17. INFORMANT
ADDRESS
Armond C. Whitlock, Cornell, CT. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undetermined
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED 2/20/85 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | ADDRESS 111 Penn St. Balto, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO Winters, W. MD | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
LEROY O. DYETT, ENSON Liberty Halls | | | 25a. DATE REC'D. BY REGISTRAR
FEB 27 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

1

Barrow, MI
June 10 1955

Unemployed

MD
No

White, Jessie
White, David
White, David

20% cotton

WINTER 1955

LeRoy D. Dietrichson
Construction 2/10/55
Baltimore, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 5 0 4 9 7 4 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ALVIN WHITESIDE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-8-85 | | | | 2b. HOUR
M | | | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-17-1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 yrs YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SC. | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2550 ARUNAH AVENUE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2550 ARUNAH AVENUE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ARTHUR WHITESIDE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAMIE MITCHELL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
217-01-3980A | | 17. INFORMANT ADDRESS
Lucinda Whiteside 2550 Arunah Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Ch. Brain Spasm -
DUE TO, OR AS A CONSEQUENCE OF Bad Luck.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch Brain Spasm.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
T. A. Furber | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-8-85 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. A. Furber | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-14-85 | | 23c. NAME OF CEMETERY OR CREMATORY
New Hope | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Blackburg County SC. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Brian Thompson F.H. | | ADDRESS
1913 W. Balto. St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

BP _____

1295

Aug 10 1892
1892



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|---|----------------------------------|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH VEDA WHITTINGTON | | | 2a DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 26, 1985 | | 2b HOUR
8:17 P.M. |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
11 5 1904 | 6 AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 9b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Inc. | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Maryland | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Dundalk | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Hugh C. Hazard | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eugenia Howe | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
213.20.4980 | | 17. INFORMANT
ADDRESS
21222 Benjamin N. Thornton 1923 Inverton Rd. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) REFRACTORY C.H.F.
DUE TO, OR AS A CONSEQUENCE OF
(c) END STAGE RENAL FAILURE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from FEBRUARY 26, 19 85, to FEBRUARY 26, 19 85, that (I) we last saw the deceased alive on FEBRUARY 26, 19 85, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I we did) did not see the body after death. | | | | | |
| 22b. SIGNATURE
L.K. Peredo | | DEGREE
M.D. | | 22c. DATE SIGNED
2/26/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L.K. PEREDO M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY BALTO., MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2/28/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, MD | | 23e. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Baltimore, MD 21222 | | 25. REGISTRAR'S SIGNATURE
Walter Brooks Bradley | | | |

9444 MOTION 2002

WOODMANTH

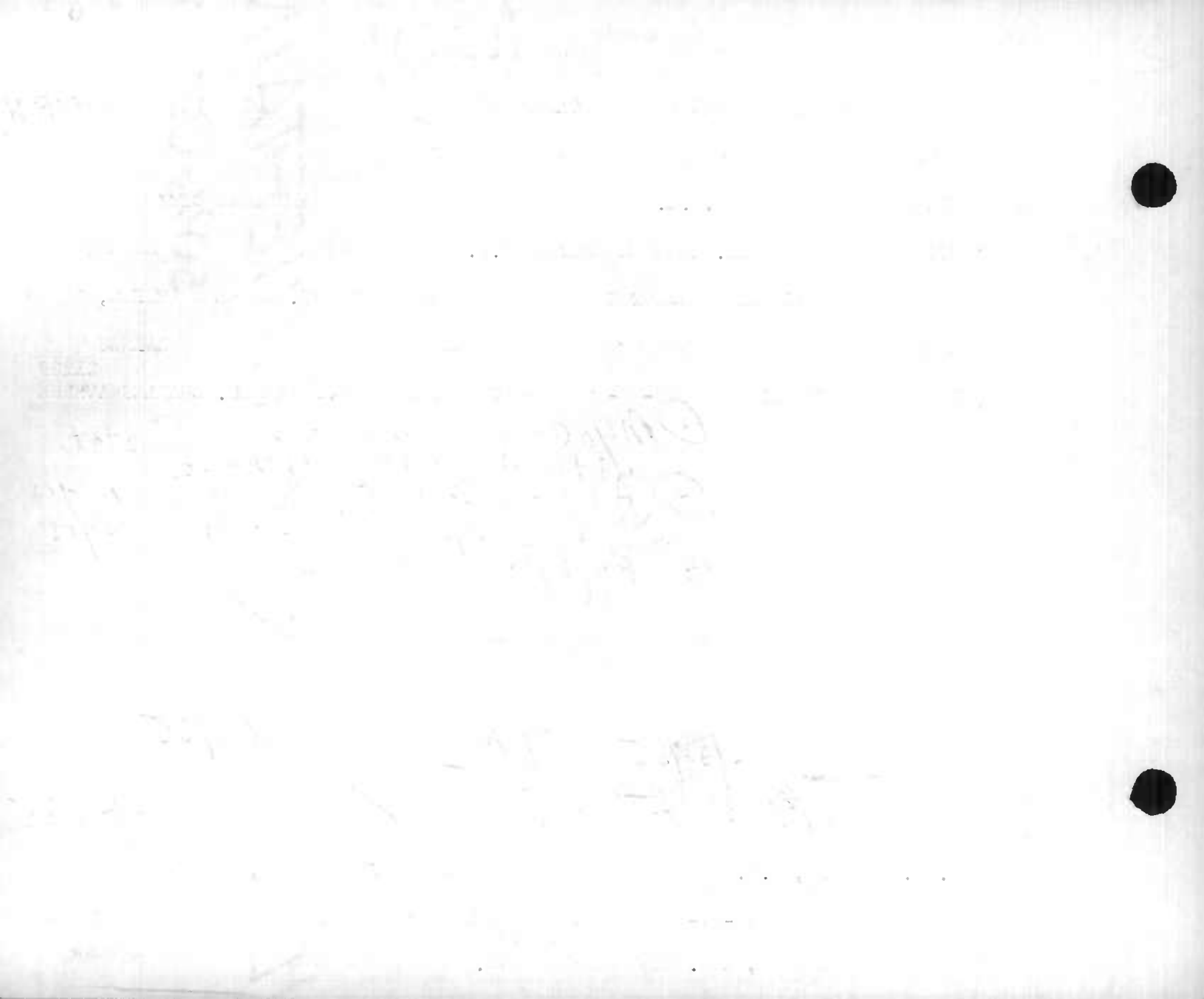
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAYNARD ARDELL WIDDOWS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 22 85 | | 2b. HOUR
1050 PM | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 09 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | 7. IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL E.R. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
BAKERY | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
ARBUTUS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
924 ST. CHARLES AVENUE, 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM WIDDOWS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAY BARNES | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 529-05-4865 | | 17. INFORMANT ADDRESS
MARY AGATHA WIDDOWS 924 ST. CHARLES AVENUE 21229 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) with Multiple Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Arterio Sclerotic Cardiovascular Disease with multiple myocardial infarctions
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Emphysema
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 stat.
10 yrs
10 yrs | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1970 2/22/85 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22/85 to 2/25/85 , that (I) saw the deceased alive on 2/22/85 , and that in my opinion death occurred on the date and hour and from the causes stated above, (I) saw the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
W. E. McGrath, M.D. | | | 22c. ADDRESS
1303 FREDERICK AVENUE, 21228 | | | 22d. DATE SIGNED
2/25/85 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
02-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GERTRUDE C. WILKINS | | | 2a. DATE OF DEATH
MONTH 2 DAY 10 YEAR 85 | | | 2b. HOUR
1410 M | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 4 DAY 25 YEAR 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN. 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONN | | 7b. CITIZEN OF WHAT COUNTRY?
MO | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
City Parks
Sale person | | | |
| 13a. STATE
MO | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
509 E. BARNEY ST 21230
BALTO. MD. | | |
| 14. FATHER'S NAME
FIRST CHARLES MIDDLE ----- LAST KIRSCHNICK | | | | 15. MOTHER'S MAIDEN NAME
FIRST Viola MIDDLE ----- LAST RILEY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
214-18-3806 | | 17. INFORMANT Mr. Louis A. Wilkins, 2902 Florida Ave,
3001 HANOVER BALT MD 21227 | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio/pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Squamous cell ca of lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (th) attended the deceased from 1/25/85 , 19____, to 2/10/85 , 19____, that (I) (we) last
saw the deceased alive on 1/25/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr Pree | | 22e. ADDRESS
3001 HANOVER BALT MD 21230 | | | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Feb. 13, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore, COUNTY Maryland STATE | |
| 24. FUNERAL DIRECTOR
NAME McGully Funeral Home, 130 E. Fort Ave. Balto. Md. ADDRESS 21230 | | | | 25a. DATE RECEIVED BY REGISTRAR FEB 13 1985 | | | |

REG. NO.

1- FOR
STATE
REGISTRAR

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE THE CERTIFICATE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP_____

DHMH - 17

(VR A15 ME (5))

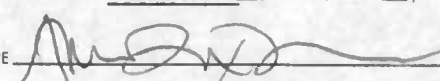
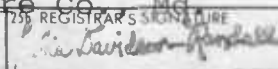


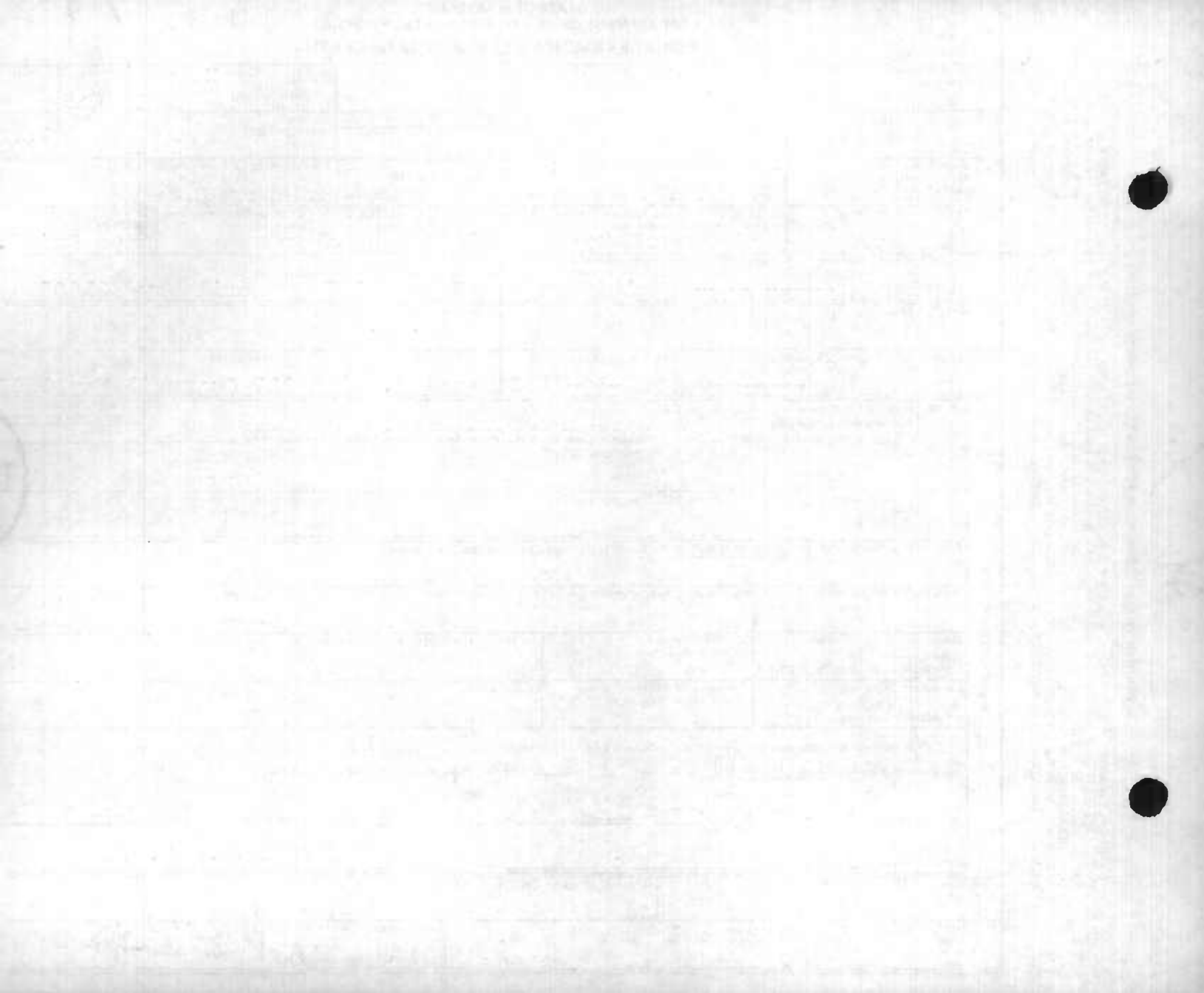
20% COTTON EIGEN

UNION MILITARY INC



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 04979 | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
VERNON Jacob WILL | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 28 19 85 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 5, 1914 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
71 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
2 28 19 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
937 Quantril Way 21205 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Labor | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Build. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
937 Quantril Way 21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? ? ? | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES)
----- | | 16b. SOCIAL SECURITY NO.
215-10-4782 | | 17. INFORMANT ADDRESS
Laura R. Will 937 Quantril Way 21205 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 3-1-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Mar 1, 85 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Dippel Funeral Homes, Inc.
7110 Belair Rd. Baltimore, Md. 21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | 25b. REGISTRAR'S SIGNATURE
 | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 8 0

1 - FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BABY GIRL WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 85 | | 2b. HOUR
243 A |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2 21 85 | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
YRS. - 06 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE HOME ADDRESS)
11a. STATE Maryland 11b. COUNTY - 11c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS ZIP CODE
2615 Harwell Ave. 21215 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David - McCleary | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sharonda - Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) anoxia secondary to abruption
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pre-maturity | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 PM 2/20 19 85 , to 2/21 19 85 , that (I) (we) lost saw the deceased alive on 2/21 19 85 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A Kaul MD | | DEGREE | | 22c. DATE SIGNED
2/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Audrey Krall | | 22e. ADDRESS
The Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
2/21/85 | | 23c. NAME OF CEMETERY OR CREMATORY
JHH | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. 21205 | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
FEB 21 8 1985 | | | |

35
33
38
300
1

MEDICAL CERTIFICATION

9
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP _____

OFFICE OF THE
ATTORNEY GENERAL
WASHINGTON, D.C.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8504981

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNIE MAE WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 85 | | 2b. HOUR
MIN.
5 45 M | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 25 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RESWICK | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Private | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Williams | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Armstrong | | 16. STREET ADDRESS & ZIP CODE
735 Stony Spring Dr. 21210 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-34-6619 | | 17. INFORMANT
ADDRESS
Estina Parson Same as 13e Daughter | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Influenza
DUE TO, OR AS A CONSEQUENCE OF (b) multiple CVA's
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
3 years | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
M. R. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-16-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
21 Feb. 85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Frazier's Funeral Home | | ADDRESS
389 Rhode Island Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 28 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NOT LIGHT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--------------|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Catherine Williams | | | | 2a. DATE KNOWN OF DEATH
XX MONTH DAY YEAR 2-20 1985 | | | | 2b. HOUR
M 8:50 P. M. | |
| 3. SEX
Female | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 7-20-29 | 6. AGE (IN YEARS
LAST BIRTHDAY) 55 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
2-20 1985 | | 7d. HOUR
P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1704 Harlem Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1704 Harlem Ave. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST ? | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Lillian Williams | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
217-24-1487 | | 17. INFORMANT ADDRESS
1838 Gladys Milburn McCulloh St. 21217 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth M.D. | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2-21-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | |

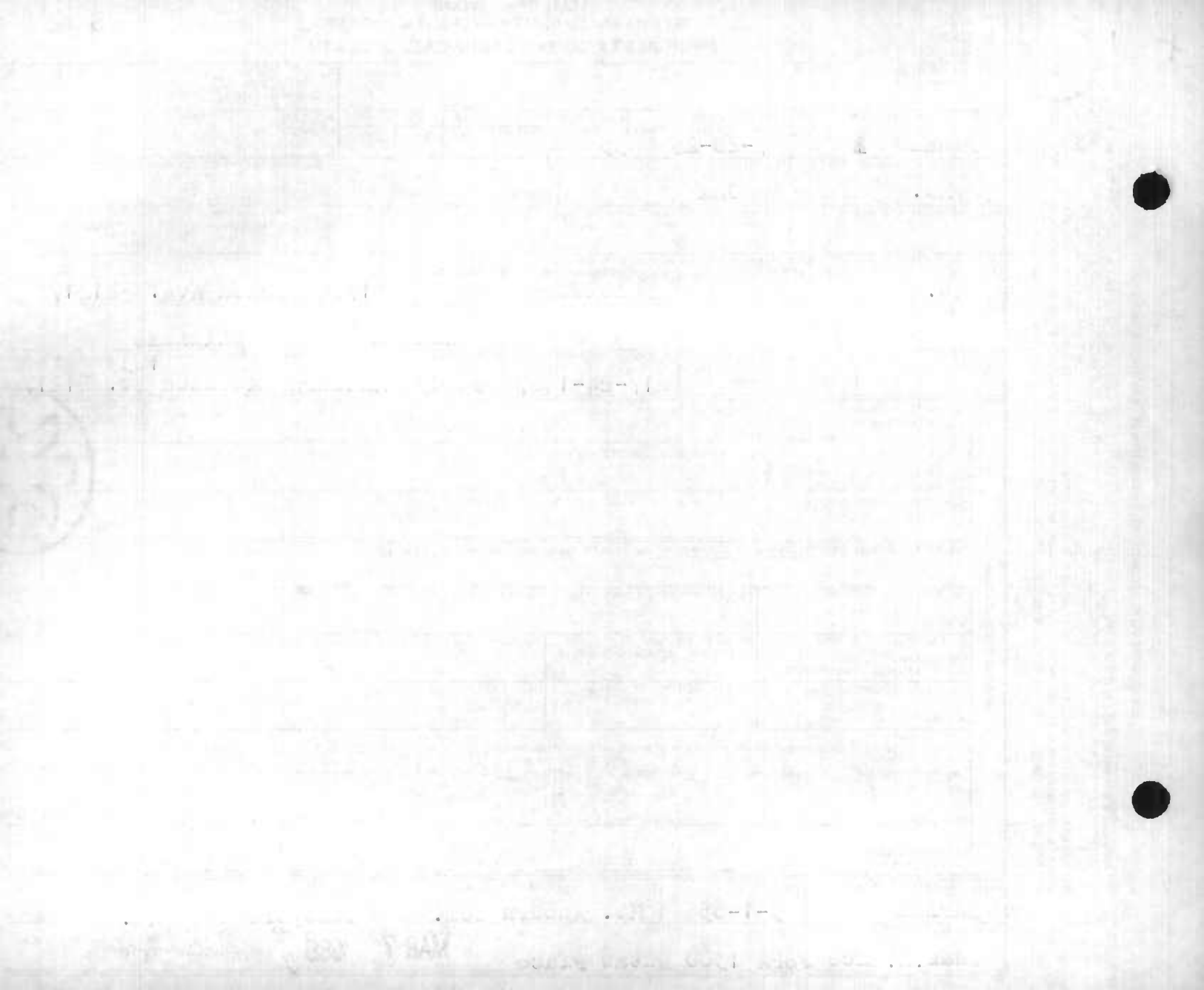
| | | | |
|--|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
3-1-85 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | 23d. LOCATION
CITY OR TOWN Westport COUNTY STATE Md. |
| 24. FUNERAL DIRECTOR
NAME Chas.A.Rice FSPA ADDRESS 1300 Eutaw Place | | 25a. DATE REC'D. BY REGISTRAR
MAR 7 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

FOR
1- STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|---|--|------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | X MONTH DAY YEAR | | 2b. HOUR | |
| Dorothy May Williams | | | | | | | | 2/ 5/ 19 85 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS | | 7c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| Female | White | Feb. 1, 1925 | | 60 YRS. | | | | 2/ 5/ 19 85 | | | | 4:50 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Francis Scott Key Medical Center | | Homemaker | | | | | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2049 Larkhall Road | | 21222 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| William Brown | | Edna MacDonald | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| No | | 224-26-4257 | | Charles P. Shiflett Balto., MD | | 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Drug Overdose | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | ? P.M. 1/29/ 19 85 | | | | subject ingested drugs | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | home | | | | 2049 Lark Hall Rd., Baltimore, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. Assistant | | | | DATE SIGNED | | | | | |
| | | | | | | | | 2/6/85 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Cremation | | | | 2/7/1985 | | Green Mount Crematory | | Baltimore City, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Walter Brooks Bradley, Inc. Balto., MD 21222 | | | | EB 6 1985 | | | | | | | | | |

333 COTTON LIGES

CHINA MARK



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 8 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|----------------|--|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Williams | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 8 85 | | | 2b. HOUR
8:15 PM | | |
| 3. SEX
m | 4. RACE
b 2 | 5. DATE OF BIRTH
MONTH DAY YEAR
3 3 22 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Grouse Creek Hospital | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Labor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
md | | | 13b. COUNTY
C | | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Williams | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anne Taylor | | | | | |
| 16a. HAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
219-09888 | | | 17. INFORMANT
Edna Mae Edwards | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | DUE TO, OR AS A CONSEQUENCE OF
(b) Septic shock | | | DUE TO, OR AS A CONSEQUENCE OF
(c) Gram negative sepsis | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/8 1985 to 2/8 1985, that (I) (we) last saw the deceased alive on 2/8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
R. Lopez | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/8/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raul Lopez | | | 22e. ADDRESS
2600 Liberty Heights | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore md | |
| 24. FUNERAL DIRECTOR
NAME
McCRIMMON FUNERAL HOME | | | ADDRESS
3207 W. NORTH AVE | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1985 | | |
| 25b. REGISTRAR'S SIGNATURE
Davidson | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please review carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their office will remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 11 is marked, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
GERALDINE B WILLIAMS | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14, 1985 | | 2b. HOUR
6:15 P | |
| 3. SEX
Female | 4. RACE
C | 5. DATE OF BIRTH
MONTH DAY YEAR
April 12, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Baltimore, Md | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Boone | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theodora White | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-24-8496 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | DUE TO, OR AS A CONSEQUENCE OF
(b) LEFT FEMORAL FRACTURE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 WEEKS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF
(c) METASTATIC BREAST CARCINOMA | | 4 WEEKS | |
| | | | | 3 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION
JAN 19, 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LEFT FEMORAL FRACTURE | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(FACILITY, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (1) this hospital attended the deceased from 1-22-85 to 2-14-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
CARLOS DEL RIO | | DEGREE
M.D. | | 22c. DATE SIGNED
FEB 14, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CARLOS DEL RIO | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
2-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1985 | |
| 25b. REGISTRAR'S SIGNATURE
Joseph L. Russ | | | | | |

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FEBRUARY 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---|---|--|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Henry WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 6, 1985 | | | 2b. HOUR P
1:05 M | | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 23 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Willoughby | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Arie | | | 13e. STREET ADDRESS / ZIP CODE
1109 Whatcoat St. 21217 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Elsie E. Williams 1109 Whatcoat St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple Organ failure | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of the stomach/esophagus. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Atrial fibrillation; Cardiac ischemia; Gastro-intestinal bleeding; Renal Failure. | | | | | | | | |
| 19a. DATE OF OPERATION
1/11/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of the stomach/esophagus | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 1 , 19 85 , to February 6 , 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 6 , 19 85 , and that in <input checked="" type="checkbox"/> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
J. T. Schwartz | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2/6/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John T. Schwartz, M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | 23b. DATE
2/11/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1985 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Jula Davidson-Randall | | | | |

MEMORANDUM

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OFF. 10/10/76



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 04987

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|------------------------------------|---|---|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James kiskaden Williams | | | 2a. DATE OF DEATH
MONTH DAY YEAR 02/21/85 | | 2b. HOUR
11:59 PM | | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 01/08/08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
BETH STEEL | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
BALT. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3627 EVERETT ST. 21226 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE WILLIAMS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY YODER | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | | | | |
| 16a. SOCIAL SECURITY NO.
173-07-0772 | | | 17. INFORMANT
MAUD WILLIAMS | | | ADDRESS BALTO. 21226
3627 EVERETT ST. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Prostatic Ca

DUE TO, OR AS A CONSEQUENCE OF

(b)

MalnutritionConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 85 to 2/21 , 19 85 , that (I) (we) last
saw the deceased alive on 2/21 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. Rahming | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2/22/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAH MING | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|---|--|------------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BROOKLYN PK. A.A.C. MD. | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home | | ADDRESS
BALTO. MD. 21225 | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Alice Brown, David Green, and Emily White. The addresses are: 101 Maple St, 202 Pine St, and 303 Cedar St.

3. The third part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Frank Black, Grace Gray, and Henry Blue. The addresses are: 404 Birch St, 505 Spruce St, and 606 Fir St.

4. The fourth part of the document is a list of names and addresses. The names are listed in the first column, and the addresses are listed in the second column. The names are: Irene Red, James Yellow, and Karen Purple. The addresses are: 707 Willow St, 808 Ash St, and 909 Hickory St.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|--|--|----------------------|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary Williams | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2 8 19 85 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11/27/12 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 72 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 8 19 85 | | 7b. HOUR 9:15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Elkridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 21227 6620 Washington Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Marx | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stack | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | |
| 16a. SOCIAL SECURITY NO. 217-01-6772 | | | | | 17. INFORMANT ADDRESS Mary Januszkiewicz/7904 Omega Crt. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) Acting Chief | | | | DATE SIGNED 2/9/85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 2/12/85 | | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR Lilly & Zeiler Inc. | | | | | | ADDRESS 1901 Eastern Ave. | | | 25a. DATE REC'D BY REGISTRAR FEB 11 1985 | | |

20% COTTON FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) RICHARD S. WILLIAMS, JR | | | 2a DATE OF DEATH MONTH DAY YEAR FEB 16 1985 | | | 2b HOUR 8 A M | | | | |
| 3 SEX Male | | 4 RACE CAUC | | 5 DATE OF BIRTH MONTH DAY YEAR 4 22 70 | | 6 AGE (IN YEARS LAST BIRTHDAY) 14 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALT. MD. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH BALT. MD. | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD. 13c CITY OR TOWN BALT 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS / ZIP CODE 2015 BEAR RIDGE RD 21222 | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST RICHARD S WILLIAMS SR | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINDA A LAWING | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b SOCIAL SECURITY NO. 214-80-5380 | | | 17 INFORMANT ADDRESS # 7200 Heards Lane #1009 77551 | | | 17b Richard S. Williams, Sr. -- Galveston, Texas | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CAF RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL TRANSPLANTATION | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on FEB 16 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE C. Medani DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 2-16-85 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) C. MEDANI | | | | | | 22e ADDRESS 22 South Green St. Balt., MD. | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 2/19/1985 | | 23c NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a DATE REC'D. BY REGISTRAR FEB 19 1985 | | 25b REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

7
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

11

FEB 16 1978

WILLIAMS

RICHARD

4 22 30

GARC

M

NSA

BALT MD

BACT MD

BACT

MD

RICHARD

WILLIAMS

214-20-230

NO

CARDIAC ARREST

~~RESPIRATORY FAILURE~~

~~RESPIRATORY FAILURE~~

RENAL TRANSPLANTATION

FEB 16 72

[Signature]

C. MEDANI

22 South George's Park, MD

X

2-16-72

5155

2015 DATE FIRST

CLAWING

214-20-230

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

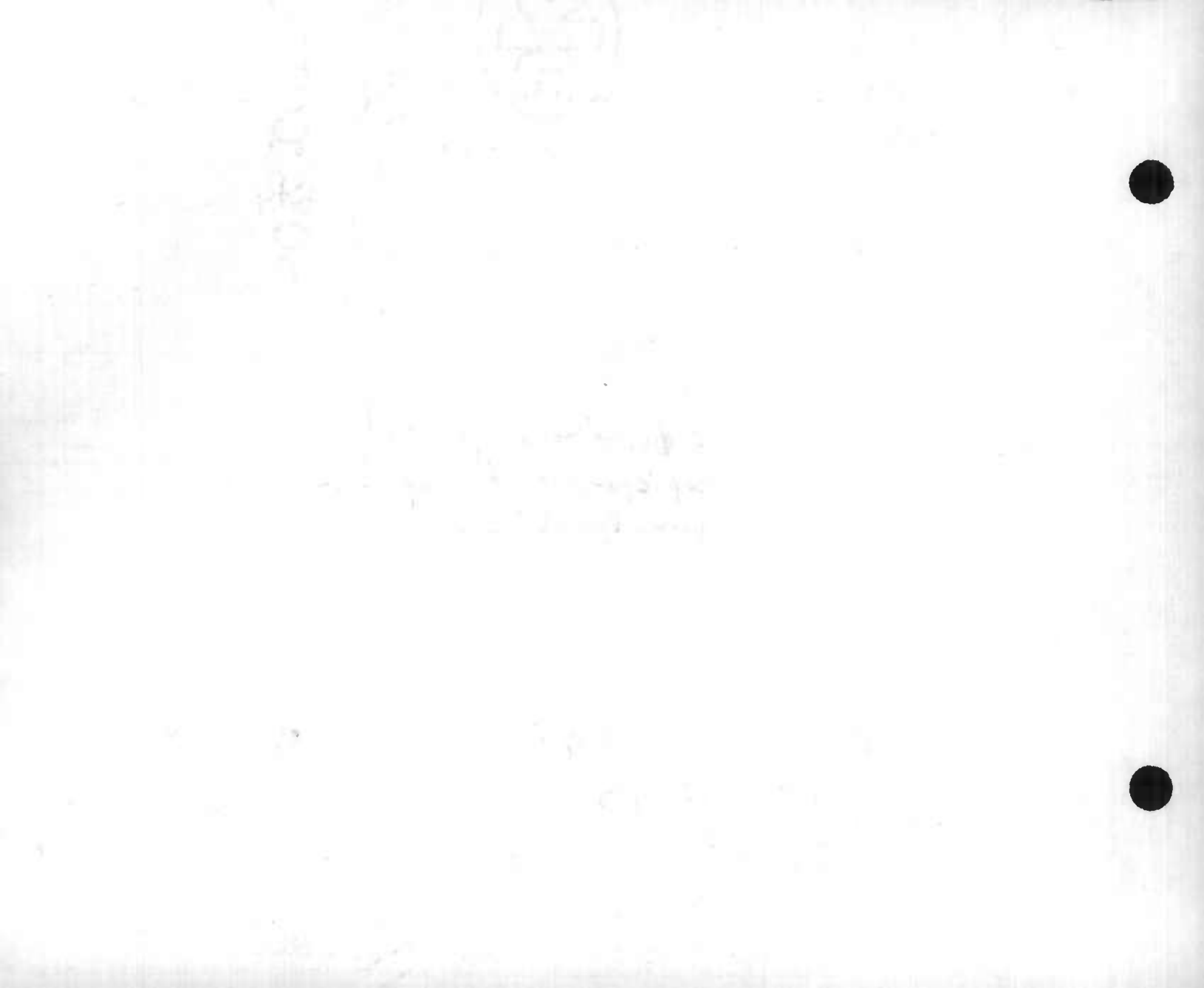
8 5 0 4 9 9 0

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Robert A Williams | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 9 85 | | |
| 3. SEX
F | | | 2b. HOUR
9 P M | | |
| 4. RACE
B | | | 5. DATE OF BIRTH MONTH DAY YEAR
10 10 17 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Ctr. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | |
| 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
2127 E. North Ave. 21213 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John H. Daniels | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary J. Barrett | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
237-24-6213 | | |
| 17. INFORMANT ADDRESS
Janet Carter 2127 E. North Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis, polyarthritis, sepsis, pneumonia.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/9 19 85, to 2/9 19 85, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Evan J Samet MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/9/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EVAN J Samet | | 22e. ADDRESS
4940 Eastern Ave Balto, MD 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem | |
| 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
Baltimore | | STATE
Md | |
| 24. FUNERAL DIRECTOR NAME
Wm C March F/H Inc. | | ADDRESS
1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR (DATE)
FEB 11 1985 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled into the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

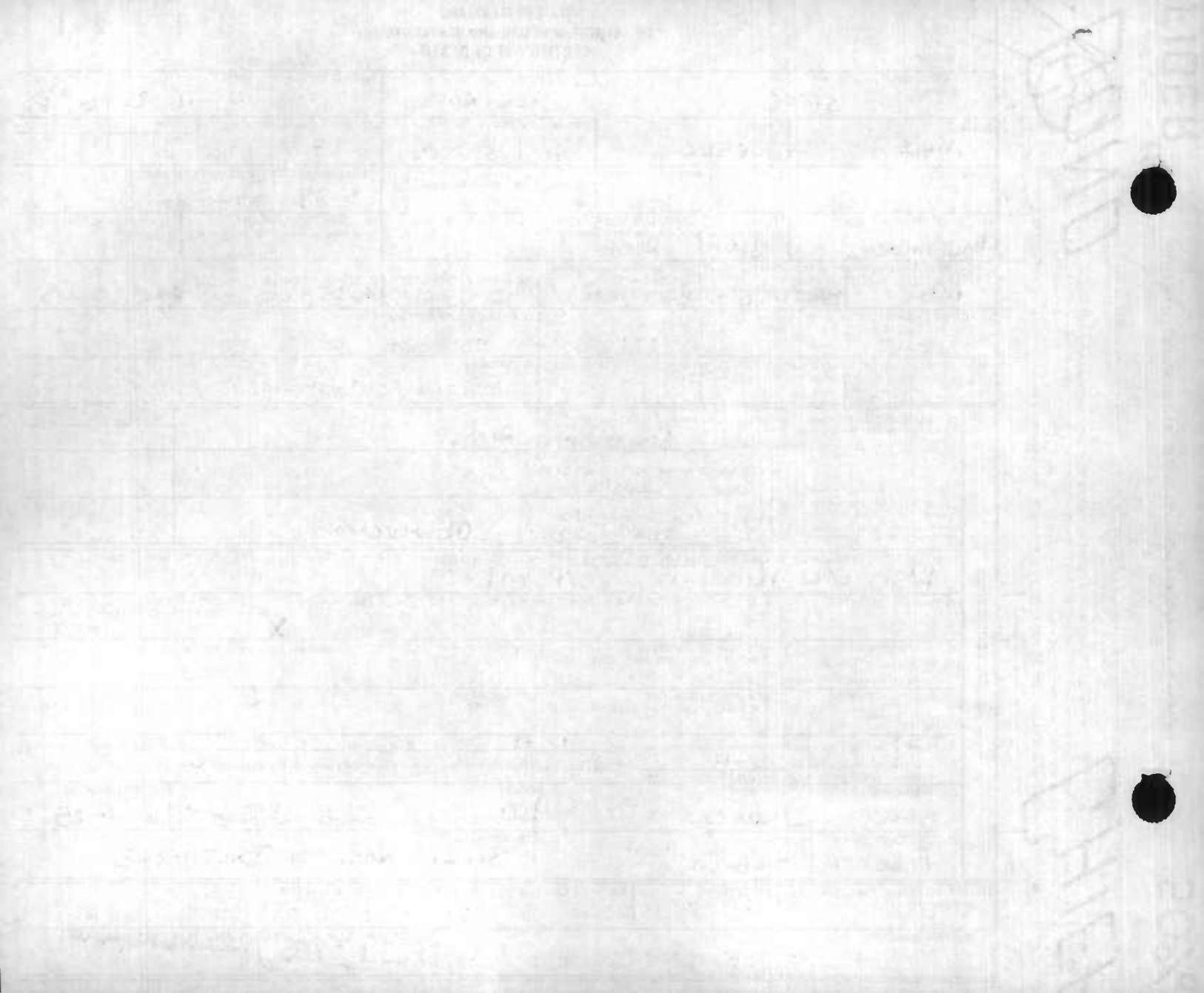
DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
STEVE WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 85 | | | 2b. HOUR
6 ²⁰ P.M. | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 5 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY Baltimore, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
4205 Ridgewood Ave 21215 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Israel Williams | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
247-03-3405 | | 17. INFORMANT
ADDRESS
Patricia Boulware 4205 Ridgewood Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Small Bowel Obstruction</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Right Lobe Pneumonia, S/P MI</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-31</u> , 19 <u>85</u> , to <u>2-11</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2-11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Roberta Tabaka | | | | DEGREE
DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-11-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERTA TABAKA | | | | 22e. ADDRESS
SINAI HOSP OF BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc, 1101 E North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 1 - 1985 | | 25b. REGISTRAR'S SIGNATURE
J. J. [Signature] | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Charles | | Williamson | | | | | | 2/ 5/ 19 85 | | 7:40 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Male | Black | 11-16-49 | | 35 YRS. | | | | | | 2/ 5/ 19 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| West Virginia | | U. S. A. | | WIDOWED | | DIVORCED | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 2216 Brookfield Ave., 2nd. fl. | | Unemployed | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 21217 | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2216 Brookfield Ave. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| James T. | | Williamson | | Ethel | | yes | | 242-84-2148 | | Curtis Williamson 1813 Edmondson Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Chronic Alcoholism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | | | (b) | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | | | (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> | | Inspection <input type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | M.D. | | Assistant | | MEDICAL EXAMINER | | DATE SIGNED 2/6/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Gregory R. Kauffman, M.D. | | ADDRESS | | 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Burial | | 2-12-85 | | Evergreen Cemetery | | Reidsville, | | North Carolina | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Bailey - Douglass Funeral Home | | Balt. MD 21217 | | FEB 7 1985 | | Julia Davidson | | Pendall | | | |

DAVID WILKINSON

PERMOTION & CO. COLTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 3

FOR
1 - STATE
REGISTRAR

REG. NO.

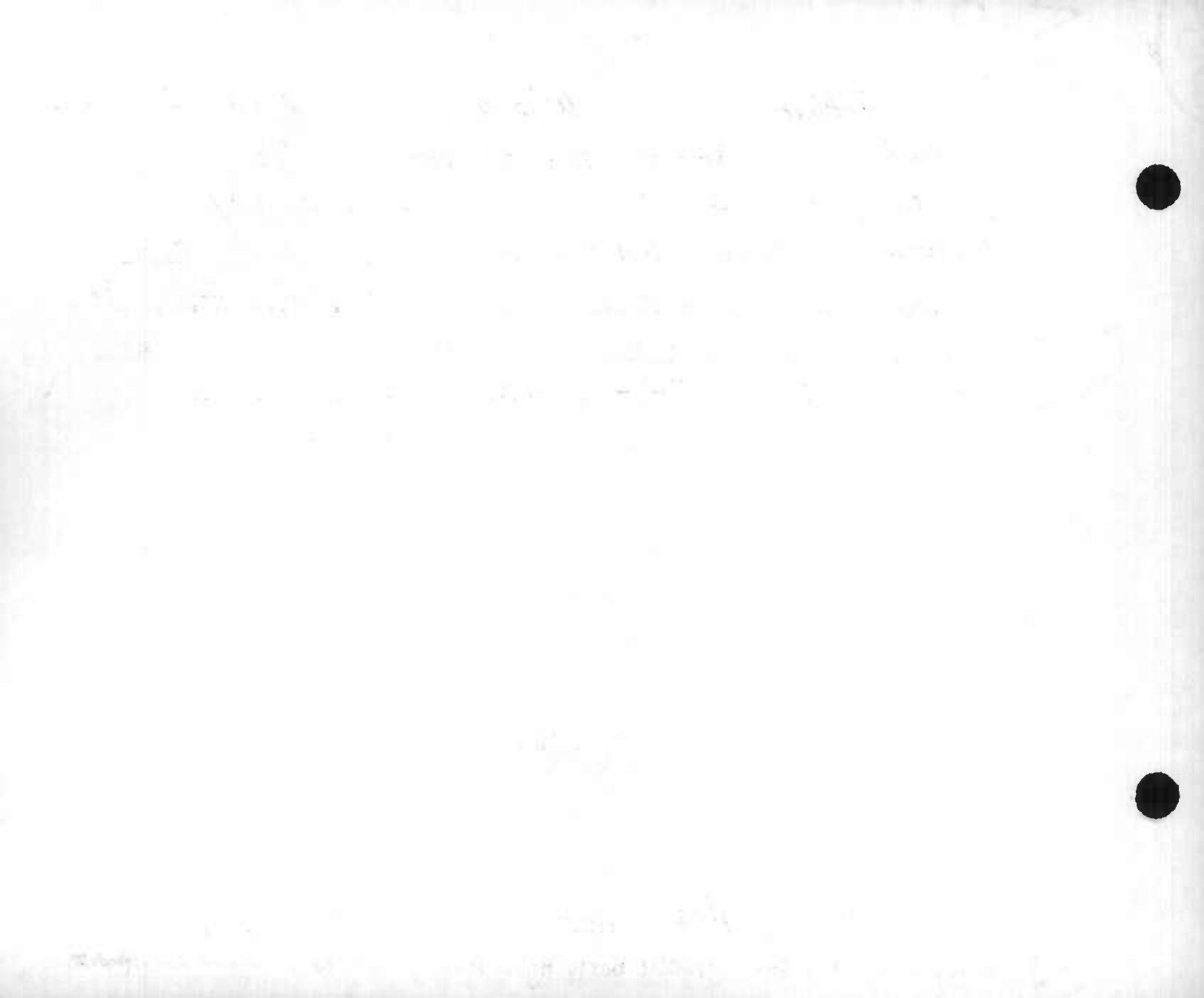
| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Arthur L Wilson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-22-85 | | | 2b. HOUR
MIN.
4:26 AM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 27 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Med Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY
BUILDING | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
N/A | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
13 N. GORMAN AVE. 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FARNEST WILSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SHALOTTIE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
BETTY WILLIAMS | | ADDRESS
3316 MENLO DRIVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Resp. failure and arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (b) Cona
DUE TO, OR AS A CONSEQUENCE OF (c) CUA x2 | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)
Insulin dependent diabetes | | | | | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/21 , 19 85 , to 2/22 , 19 85 , that (I) (we) lost
saw the deceased alive on 2/21 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ronald E. Wisl MD
DEGREE | | | | | | 22c. DATE SIGNED
2/22/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ronald I Wisl | | | | | | 22e. ADDRESS
Univ of Md Hosp 225 Greenest | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBITUS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett & Son | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 4

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANCES LOUISE WILSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 5 85 | | | 2b. HOUR
12:30 P. | | | | | |
| 1. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 22 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7. IF UNDER 24 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3005 Lorena Avenue | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Wall Scaping Bus. | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3005 Lorena Avenue 21230 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James R. Watkins | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Griffis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
215-28-7413 | | 17. INFORMANT ADDRESS
William R. Wilson 405-B Marshall Ct. 20707 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Metastatic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c) Heart CoronerAPPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate6 mo22 mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

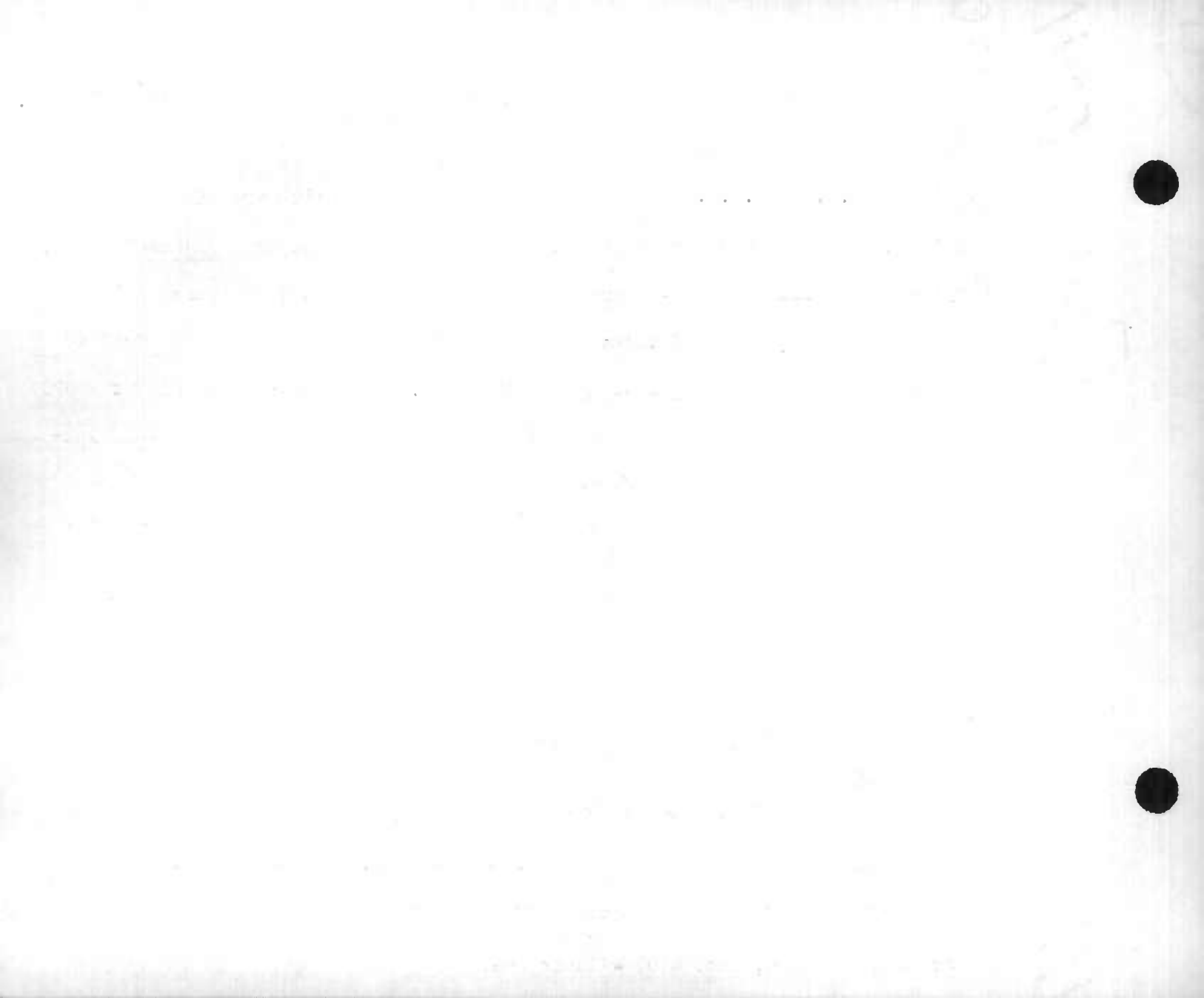
MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/25</u> , 19 <u>83</u> , to <u>2/5</u> , 19 <u>85</u> , that (I) (we) last saw the decedent alive on <u>2/1</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE
<u>Wm C Waterfield MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/6/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Waterfield | | | | 22e. ADDRESS
St. Agnes Hosp. Oncology Dept. | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 7 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 5

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|---|-------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gladys Wilson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 21, 1985 | | 2b. HOUR
5:05^P | |
| 3. SEX
Female | | 4. RACE
Col. 2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-15-1906 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 8. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 14. KIND OF BUSINESS OR INDUSTRY | | |
| 15. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Maryland | | 15b. COUNTY
BALTO. | | 15c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
James McCray | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Gibbinson | | 18. STREET ADDRESS / ZIP CODE
3232 Normount Ave. 21216 | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 19b. SOCIAL SECURITY NO.
212-22-1034 | | 19c. INFORMANT
ADDRESS
Mrs. Rebecca Wilson 3232 Normount Ave. 21216 | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Arrhythmia and Hypotension
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 Hours | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21g. INJURY OCCURRED:
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21h. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (x) (this hospital) attended the deceased from February 10, 1985 to February 21, 1985 , that (x) (we) lost saw the deceased alive on February 21, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (y) (we) did (not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Barbara Sanfelmo | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/21/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Barbara Sanford, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-28-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. Co. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph L. Russ 2322 W. North Ave. | | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 26 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | |

MEDICAL CERTIFICATION

RECEIVED



WIND

RECEIVED

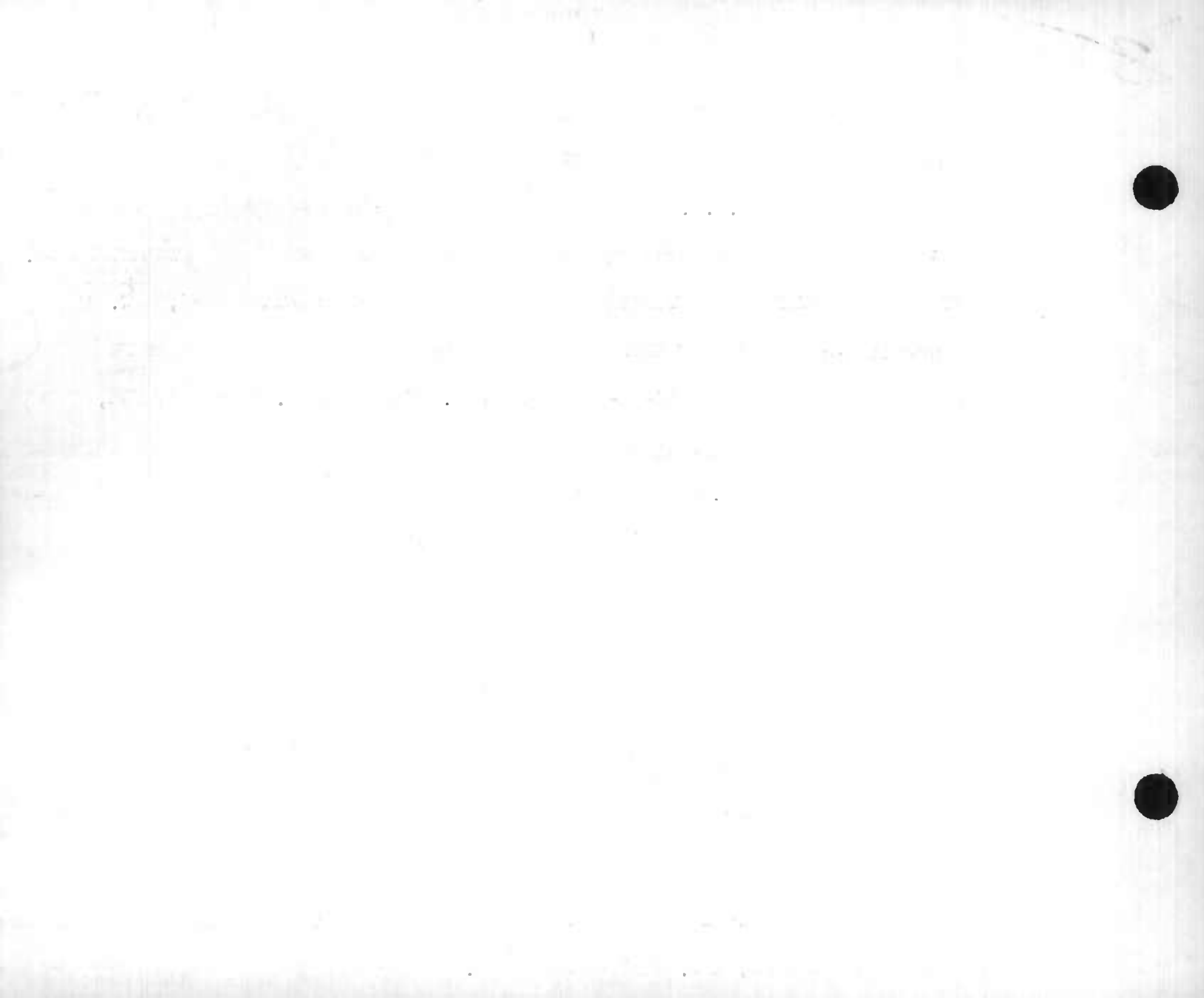


FEB 25 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 6

| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JAMES ARTHUR WILSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Feb 17 85 | | 2b. HOUR
7:40 AM | |
| 1. SEX
MALE | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
03 28 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FOREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
TELEPHONE CO. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
CATONSVILLE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unavailable WILSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
IVY FINK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-14-0768 | | 17. INFORMANT ADDRESS
HELEN A. WILSON 525 N. DECKER AVENUE, 21205 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiovascular + respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral AKA
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrhythmias
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-13- 19 85 to 2-17 19 85 , that (I) (we) last saw the deceased alive on 2-17 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Anita Patt | | DEGREE
NO | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-17 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANITA Patt, MD | | 22e. ADDRESS
St Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02-20-85 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR NAME
HUBBARD FUNERAL HOME, INC. | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 20 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical investigation must be carried out.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 7

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1 DECEASED NAME
(119b USE PREFIX)
FIRST MIDDLE LAST
ROBERTA GABRIELLE WILSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 25 85 | | | 2b. HOUR
945 A M | |
| 1 SEX
F | | 4 RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 09 39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FRANCE | | 7b. CITIZEN OF WHAT COUNTRY?
FRANCE | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
HAVRE DE GRACE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
288 WILSON ST 21078 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDRE ROSIER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LUCY FURHMANN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
547-08-6171 | | 17. INFORMANT ADDRESS
CYRIL DEMERS 288 WILSON ST. HAVRE DE GRACE MD | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC BREAST CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
5 YEARS | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from February 1, 19 85, to February 25, 19 85, that (1) (we) last saw the deceased alive on February 25, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael J. Buchanan MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL J. BUCHANAN MD | | 22e. ADDRESS
22 S. GREENE ST., BALTIMORE MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
FEB. 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
SPESUTIA EPISCOPAL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PERRYMAN, HARFORD, MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3355 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 7. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Susie Jones Wilson | | | | 7b. HOUR
3:15 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
3 2 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Constant Care Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Lee Boyd Jones | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Christine Baucom | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
829 N. Fremont Ave. 21217 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
220-18-3666 | | 17. INFORMANT ADDRESS
Frederick Wilson 1804 Thomas Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertensive Arteriosclerotic Cardiovascular Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10-12 min | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Diabetes Mellitus, Chronic Congestive HEART FAILURE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1, 1984, to February 8, 1985, that (I) (we) lost
saw the deceased alive on Jan 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert C. Blackmon, M.D. | | DEGREE
M.D. | | | | 22c. DATE SIGNED
2/11/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Blackmon, M.D. | | 22e. ADDRESS
Constant Care Medical Center
1501 - Division St. Balt. Md. 21217 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville, Md. | |
| 24. FUNERAL DIRECTOR NAME
Wm C March F/H Inc. 1101 E North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 4 9 9 9

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANNA Faith WINDLE | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 - 1 - 85 | | | 2b. HOUR 2:15p m | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 24 84 | | 6. AGE (IN YEARS LAST BIRTHDAY) 1 month YRS. MONTHS 39 DAYS 39 HOURS 39 MIN. | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RANSON, WV | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE W VA COUNTY Berkeley | | 13b. CITY OR TOWN MARTINSBURG | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 322-1/2 Boyd Ave. 25401 | | 13e. STREET ADDRESS / ZIP CODE 99999 | |
| 14. FATHER'S NAME FIRST JOHN MIDDLE Clayton LAST WINDLE | | 15. MOTHER'S MAIDEN NAME FIRST LISA Ann MIDDLE Herndon LAST WINDLE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT John Windle CHART ADDRESS 322 1/2 Boyd Avenue Martinsburg, WV 25401 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY INSUFFICIENCY**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **OSTEOGENESIS IMPERFECTA - LETHAL TYPE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|--|--|---|--|
| 22b. SIGNATURE Linda L. Wright, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 2/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA L. WRIGHT | | 22e. ADDRESS 22 30 GREENE ST BALTIMORE MD | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | 23b. DATE FEB 5, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Windle Family Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY Hedgesville Berkeley WV | |
| 24. FUNERAL DIRECTOR NAME Charles M Brown | | 24b. DATE REC'D. BY REGISTRAR FEB 13 1985 | | 24c. REGISTRAR'S SIGNATURE Julien Davidson-Rodella | | | |



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NO. 1378



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WATER WIN 2000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505001

FOR
1 -
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROSE C. WINTERLING | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 16, 1985 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 17, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
5506 Summerfield Ave (Residence) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
5506 Summerfield Ave. 21206 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Gillen | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cecilia Horan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
No | | 16b. SOCIAL SECURITY NO.
217-26-0296 | | 17. INFORMANT ADDRESS
21206 Frederick J. Winterling 5506 Summerfield | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest causing asystole</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<i>essential hypertension; diabetes mellitus</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) the hospital attended the deceased from <u>7</u> 19 <u>81</u> to <u>2</u> 19 <u>85</u> , that (I) was last saw the deceased alive on <u>2-5</u> 19 <u>85</u> , and that in (my) your opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Frank S. Palmisano Jr</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-18-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Frank S. Palmisano Jr. M.D. | | | | 22e. ADDRESS
5122 Harford Road Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb 20 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>Gelia Davidson-Randall</i> | |

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35
00
35
00

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

February 10, 1955

Mr. J. Edgar Hoover

Director, FBI

Washington, D.C.

Re: [illegible]

Dear Sir:

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

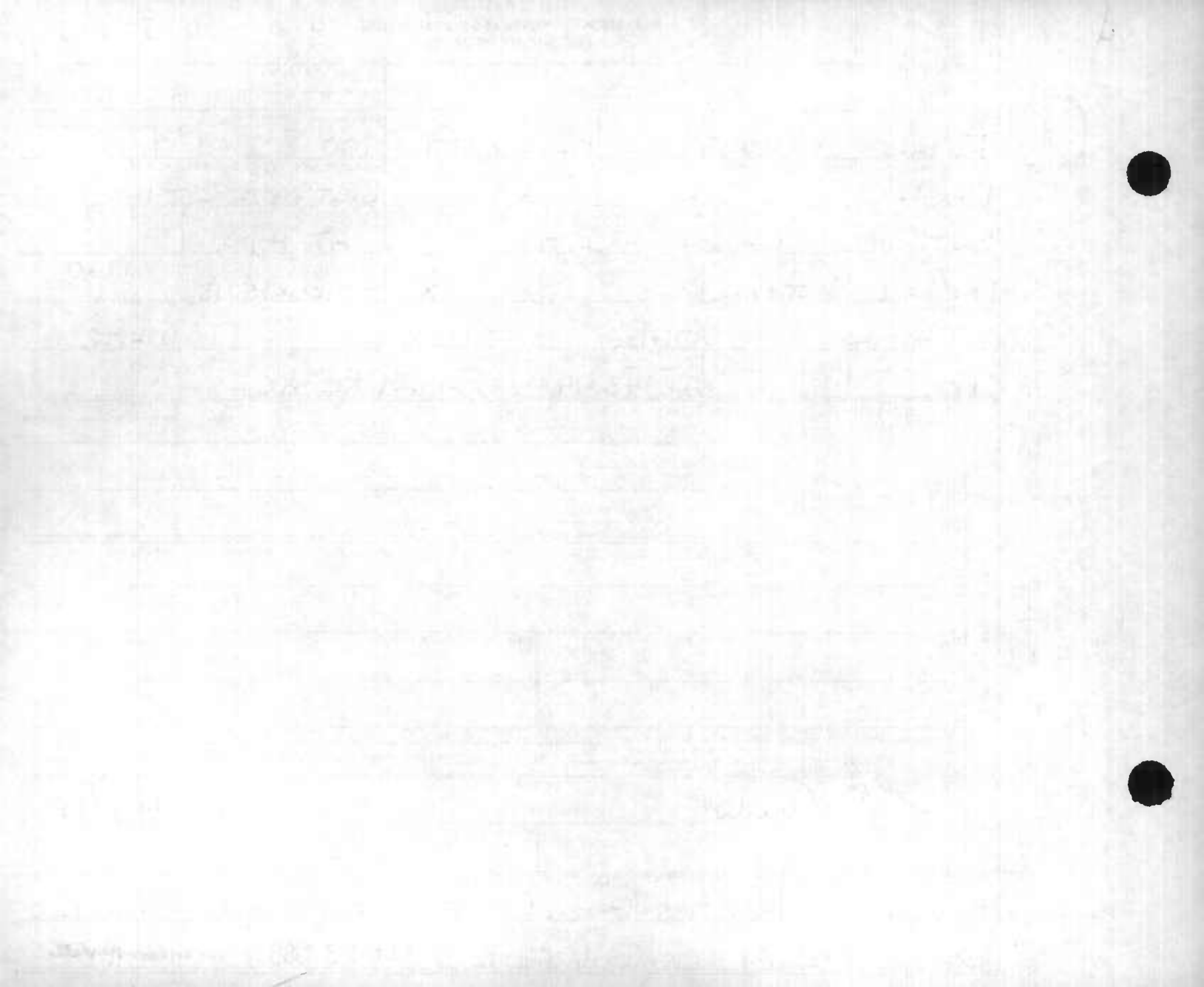
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed - first to health officer, then to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8505002 | | | |
|--|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY O. WISEMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEBRUARY 5, 1985 | | 2b. HOUR
10:55P | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 10, 1884 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
100 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
AT Home | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
T. Thomas | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ellen White | | 13e. STREET ADDRESS / ZIP CODE
P.O. Box 15315 21220 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216143274 | | 17 INFORMANT
FAMILY RECORDS | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 16, 1985 , to FEBRUARY 5, 1985 , that (XX) last saw the deceased alive on FEBRUARY 5, 1985 , and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
L. K. Peredo | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/5/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. K. PEREDO | | 22e. ADDRESS
100 NORTH BROADWAY 21231 CHURCH HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 9, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME
EVANS CHAPEL OF MEMORIES | | ADDRESS
2020 HARTFORD ROAD | | 25a. DATE REC'D. BY REGISTRAR
FEB 13 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Ponder | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) AKA STANISLAWA WISNEWSKA
Stella Wisniewski | | 2a. DATE OF DEATH 2/18/85 | | 2b. TIME OF DEATH 1 PM | |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH Nov 2, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Belleville Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | 13b. COUNTY A.A. | 13c. CITY OR TOWN Brooklyn | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 5709 Magie Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Antkiewicz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Demicki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 705-03-5183 | | 17. INFORMANT ADDRESS Mildred Keiser Same as 13 e | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure & Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 DAYS
15 YRS |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from JAN 22 , 19 79 , to 2-18 , 19 85 , that (we) lost saw the deceased alive on 2-18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John F. Hartman MD | | DEGREE MD | | 22c. DATE SIGNED 2-18-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN F. HARTMAN | | 22e. ADDRESS JENKINS-1000 S CATON AVE 21229 | | | |

| | | | |
|--|--------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2/21/85 | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md. |
| 24. FUNERAL DIRECTOR NAME George J. Gonce | | 25a. DATE REC'D. BY REGISTRAR FEB 19 1985 | |
| 25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-1941

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 0 0 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Joseph T. Wisniewski | | | 2a DATE OF DEATH MONTH DAY YEAR
2 28 85 | | 2b HOUR
11:25 AM |
| 3 SEX
Male | 4 RACE
Cauc. | 5 DATE OF BIRTH MONTH DAY YEAR
9 18 10 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b KIND OF BUSINESS OR INDUSTRY
American Std. |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Dundalk | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Constanti Wisniewski | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances Depczynski | | 16a ADDRESS
320 Polcroft Street Balto., MD., 21224 | |
| 16b WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16c SOCIAL SECURITY NO.
213-05-6638 | | 17 INFORMANT
Dolores J. Wajer | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio-Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) advanced carcinoma of
DUE TO, OR AS A CONSEQUENCE OF
(c) lectin
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION
2/26/85 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Porto-cath of Jejunum | | 19c AUTOPSY?
NO | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21a TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21b HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/23 1985 to 2/28 1985 , that (I) (we) lost saw the deceased alive on 2/28 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Bryan S. Nolan, M.D. | | DEGREE
M.D. | | 22c DATE SIGNED
2/28/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Bryan Nolan, M.D. | | 22e ADDRESS
Good Sam. Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
3/4/1985 | | 23c NAME OF CEMETERY OR CREMATORY
Sacred Ht. Of Jesus | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Dundalk Baltimore Maryland | | 23e LOCATION
CITY OR TOWN COUNTY STATE
Dundalk Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR NAME
Duda-Ruck, Inc. | | ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | 25a DATE REC'D. BY REGISTRAR
MAR 6 1985 | |
| 25b REGISTRAR'S SIGNATURE
Davidson-Randall | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505005

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
B. BERNARD R. WOHLKE | | | 2a DATE OF DEATH
MONTH DAY YEAR
2 15 85 | | | 2b HOUR
10 15 AM | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
7 28 01 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALT. CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALT. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | | | 12a USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Rate Clerk | | 12b KIND OF BUSINESS OR INDUSTRY
B&O Railroad | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Lansdowne | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
2225 Smith Avenue 21227 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John C. Woehlke | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise C. Fischer | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
705-05-7838 | | 17 INFORMANT
ADDRESS
Louise C. Woehlke 225 Smith Ave. 21227 | | | | | |

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) sepsis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

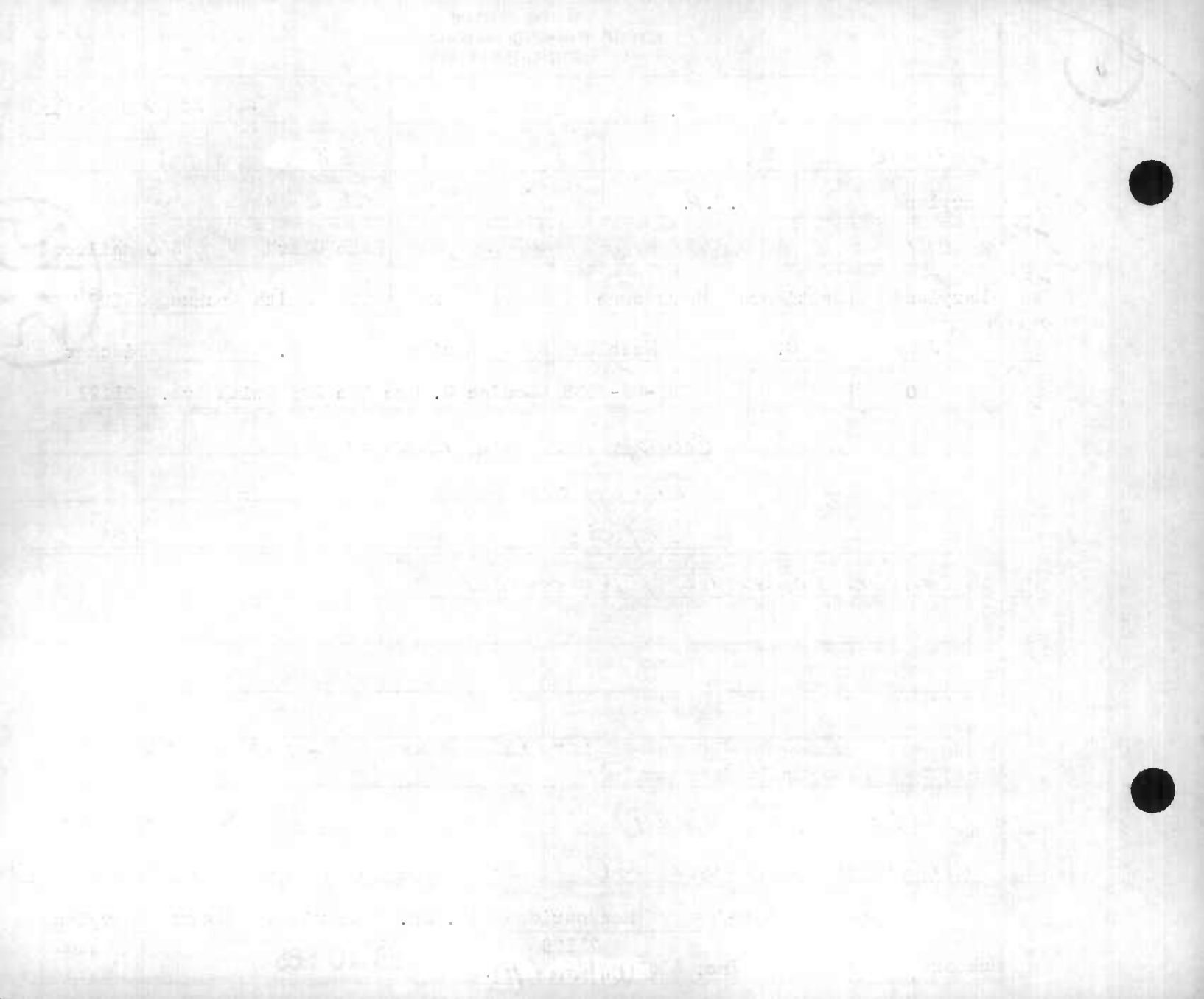
Senile Dementia, Depression

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) this hospital attended the deceased from <u>1/4/85</u> , 19 <u>85</u> , to <u>2/15</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>2/15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Deborah Thompson MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/15/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DEBORAH THOMPSON MD</u> | | | | 22e. ADDRESS
<u>22 S. Greene Street Baltimore MD</u> | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | |
| 24 FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24b. ADDRESS
21229 | | 25a DATE REC'D. BY REGISTRAR
FEB 20 1985 | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

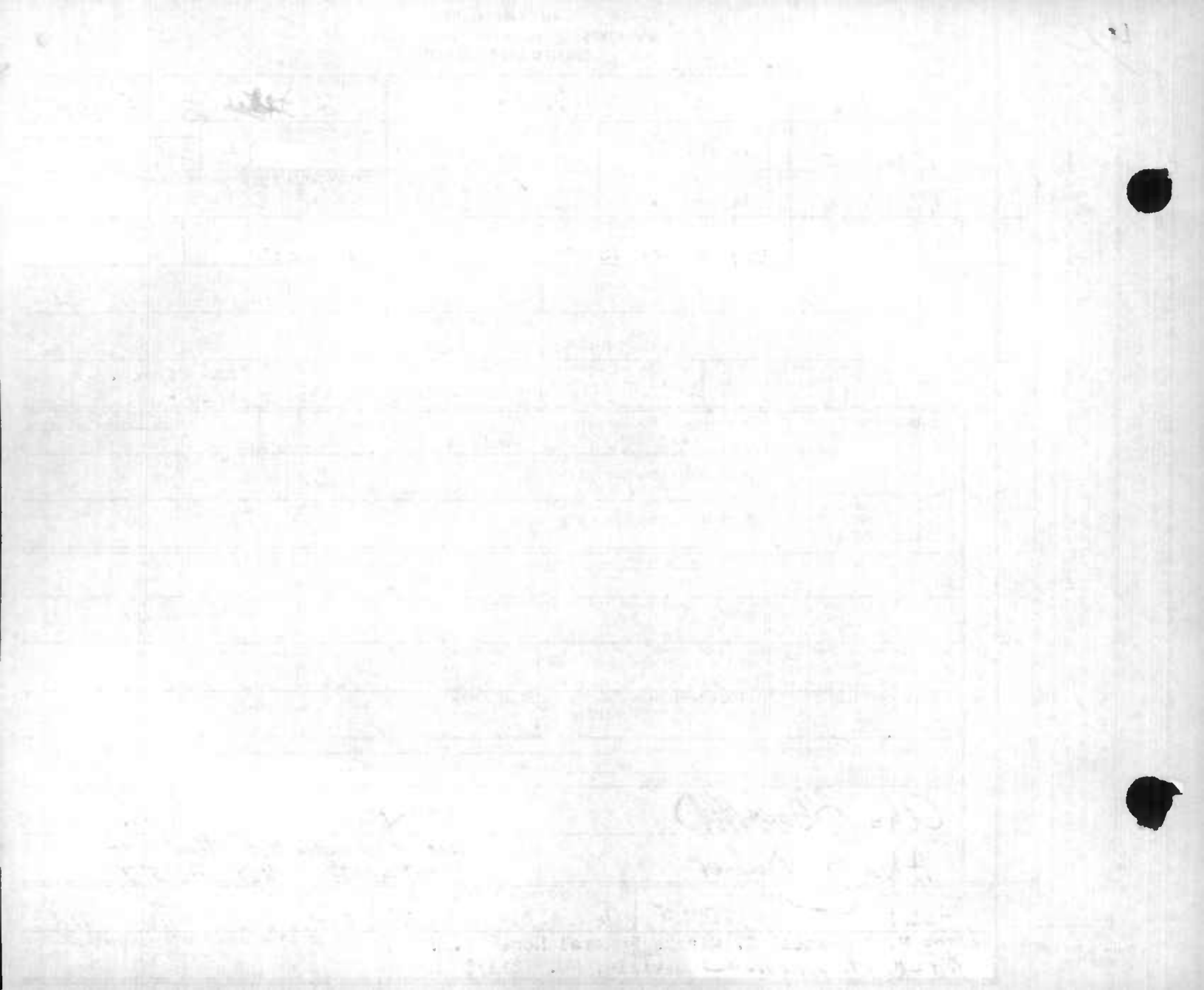
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| FOR STATE REGISTRAR | | Hazel G. Woodall | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 5 0 5 0 0 6 | |
|--|---|--|------------------------------------|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| Hazel G. Woodall | | | | 2-23-85 | | 10P ²⁰ M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. MONTHS DAYS HOURS MIN. | |
| FEMALE | White | 3 12 1993 | | 91 | | 11 23 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| Virginia | U.S.A. | | | Balt. City | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY OR COUNTY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | Uplands Home for Church Women | | | Housewife | | Home | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| Md. | | City | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4501 Old Frederick Rd | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | |
| John G. Guthrie | | | Mary Broughton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 214-46-9646 | | Same as Sec. 13 | | | |
| | | | | Uplands Home For Church Women - | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Cancer of pelvis | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| Alva S. Baker MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | Feb. 23, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Alva S. Baker | | 218 Washington Hts Blvd Ctr Westminister MD 21157 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | 2/23/85 | Travis Ridge Cemetery | | Baltimore City | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Ave., Catonsville, MD. 21228 | | | | FEB 20 1985 | | [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3505007

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FLORENCE WOODARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/1/85 | | 2b. HOUR 4A. M |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 01/02/19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unkn | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn | | 13e. STREET ADDRESS / ZIP CODE 4504 Garden Drive 21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-24-4125 | | 17. INFORMANT ADDRESS Arminta Lyle 4504 Garden Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Lung Ca (b) Lung Ca DUE TO, OR AS A CONSEQUENCE OF (c) Lung Ca | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE M. Antos MD | | DEGREE | | 22c. DATE SIGNED 2/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Antos MD | | 22e. ADDRESS Univ. Md Hosp. | | 22f. PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 02/04/85 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Park | |
| 23d. LOCATION CITY OR TOWN Randallstown | | COUNTY | | STATE MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Gisha Davidson-Randall | |

BP

(11)

PROBABLE - located

Black 1 of 1

Baltimore City

University Hospital

Cardioballoon catheter

DR. B. L. F.

2/1/82 X

Mr. Carter
MD
MD
MD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 0 0 8

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Mowen WOODEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 25, 1985 | | 2b. HOUR P
2:38 M |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 31, 1916 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3501 St. Paul Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Funeral Director | | 12b. KIND OF BUSINESS OR INDUSTRY
Funeral |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3501 St. Paul Street 21218 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Franklin Wooden | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Lee Harris | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-14-8916 | | 17. INFORMANT
ADDRESS
Self - August, 1977 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESP. ARREST | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> DUE TO, OR AS A CONSEQUENCE OF
 (b) METASTATIC BLADDER CA.
 DUE TO, OR AS A CONSEQUENCE OF
 (c) </div> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
C.H.F. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG. 13, 1981 , to FEB. 25, 1985 , that (I) (we) last saw the deceased alive on FEB. 25, 1985 , and that in (my) (our) opinion death occurred on the date and hour (and from the causes stated above, if (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Horst K. A. Schirmer | | 22c. ADDRESS
Suite 202
201 E. University Pkwy. Balto., Md. 21218 | | 22d. DATE SIGNED
Feb. 26 1985 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/1/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville, Balto. Co., Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
STEWART & MOWEN CO., 108 W. North Ave. 21201 | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 28 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



5191 678 (105)

4.2.5

0198-41-012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505009

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ruth G. Woolley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 85 | | 2b. HOUR
M |
| 3. SEX
Fem. | 4. RACE
Cau. | 5. DATE OF BIRTH
MONTH DAY YEAR
11 1 22 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mercy Hosp. | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
702 Beaumont Ave. 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cecelia Hobbs | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-12-7086 | | 17. INFORMANT
ADDRESS
Patricia Rotundo 8164 Kavanagh Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Huntington's Chorea</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JAN 1</u> , 19 <u>84</u> , to <u>FEB 18</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>JAN 14</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Howard H. B. M. D.</u> | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>2/18/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-21-85 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc. 6415 Belair Rd. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 21 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Robertson-Randall</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

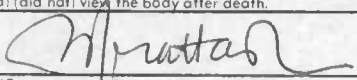

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
1 - STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT) BABY BOY WOOTEN | | | 2a DATE OF DEATH MONTH FEB. DAY 8, YEAR 1985 | | 2b HOUR 1:24 A M |
| 3 SEX
Male | 4 RACE
Black | 5 DATE OF BIRTH
MONTH FEB DAY 7, YEAR 1985 | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS 7 | IF UNDER 1 YEAR
MONTHS 13 DAYS 36 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE CITY | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | 12b KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Md 13b COUNTY 13 13c CITY OR TOWN BALTO | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 00000 | | | |
| 14 FATHER'S NAME
FIRST BERNADETTE MIDDLE COBB LAST COBB | | 15 MOTHER'S MAIDEN NAME
FIRST BERNADETTE MIDDLE COBB LAST COBB | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NA | | 16b SOCIAL SECURITY NO.
NA | | 17 INFORMANT ADDRESS | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) SEVERE HYALINE MEMBRANE DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) PREMATURITY | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
PNEUMOTHORAX ; POSSIBLE SEPSIS | | | | | |
| 19a DATE OF OPERATION
NA | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY NA
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
NA | | | |
| 21d INJURY OCCURRED NA
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e PLACE OF INJURY NA
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION NA
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Feb. 7 , 19 85 , to Feb. 8 , 19 85 , that (I) (we) last
saw the deceased alive on Feb. 8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
 | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED
2/8/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
ISABELITA G. FRATTAROLA | 22e ADDRESS
UNIV. OF MARYLAND HOSP. (BALTIMORE, MD) | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) Removal | 23b DATE
2/14/85 | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24 FUNERAL DIRECTOR
NAME Anatomy Board ADDRESS Balto., Md. | 25a DATE REC'D. BY REGISTRAR
FEB 22 1985 | 25b REGISTRAR'S SIGNATURE
 | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | Dorothy A. Wujek | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| DOROTHY | | A | | WUJEK | | | | 2 9 85 | | 5:13 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| FEMALE | | WHITE | | 8 13 19 | | 65 YRS. | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | | SINAI HOSPITAL | | Home Maker | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| BALTIMORE | | BALTIMORE | | BALTIMORE | | | | 2607 WINDSOR RD 21234 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| John Beckman | | Dorothea Miller ^{AST} | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 217-09-8355 | | 17. INFORMANT ADDRESS | | Mr John W Beckman 3103 Putty Hill Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) ASCVD | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| HTN Hypothyroidism | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (1) (This hospital) attended the deceased from 2-7-19-85, to 2-9-19-85, that (1) (we) last saw the deceased alive on 2-9-19-85, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| J. M. Moll, M.D. | | M.D. | | | | | | 2-9-85 | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22b. ADDRESS | | | | | | | | | |
| J. M. Moll, M.D. | | SINAI HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 2/12/85 | | Holy Rosary | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J Ruck Inc. | | Baltimore, Maryland | | | | FEB 11 1985 | | John Davidson-Randall | | | |

RECEIVED



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 0 1 2

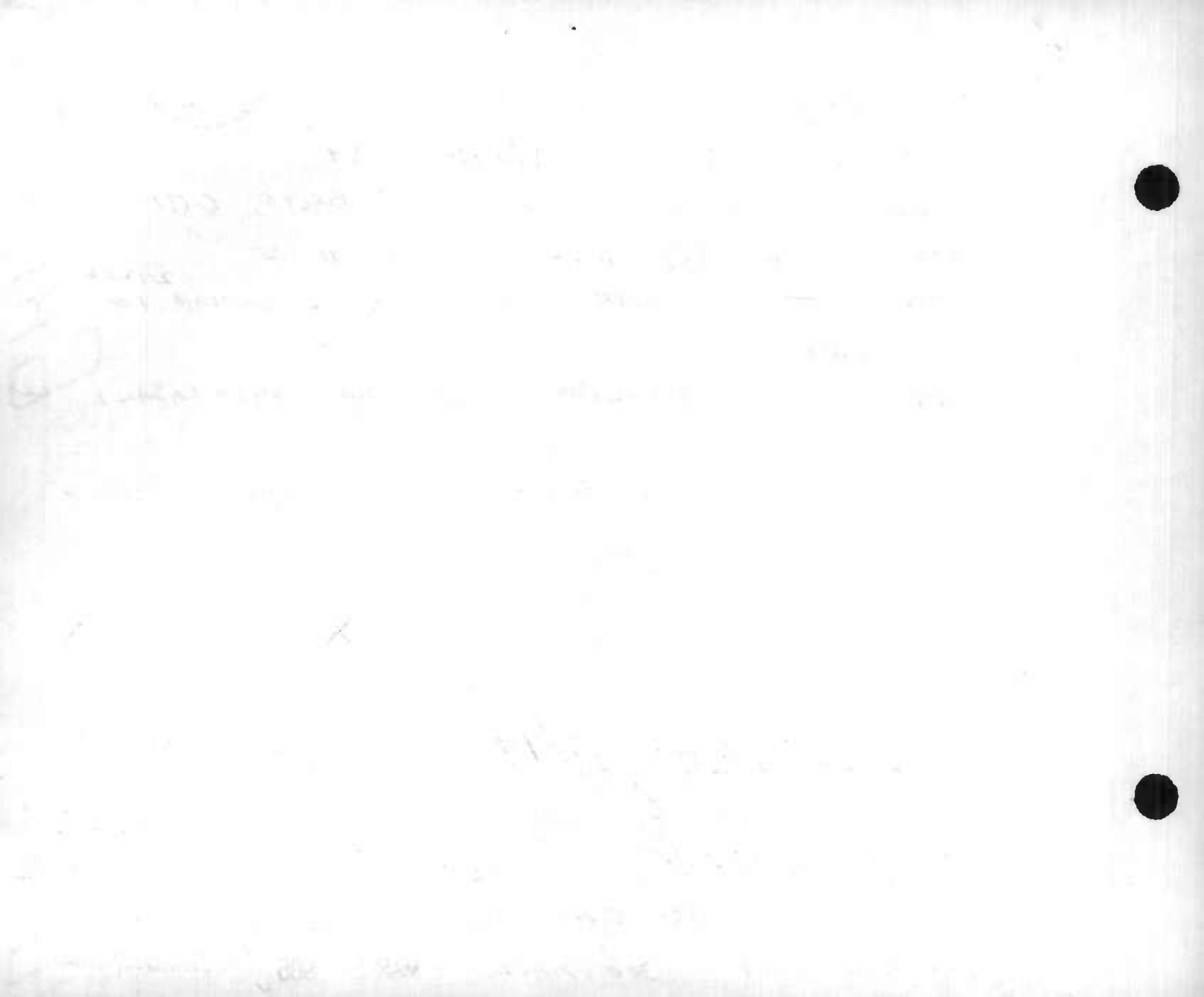
FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret Wyant | | | 2a. DATE OF DEATH
MONTH DAY YEAR 2 25 85 | | | 2b. HOUR
10 23 M | | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR 9/15/30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
F.S. KEY M.C. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD. | | | 13b. COUNTY
— | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5356 SINCLAIR AVE 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217-26-2839 | | 17. INFORMANT
ADDRESS
EMERSON RAY 4924 LASALLE LN | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Liver Failure of unknown etiology
DUE TO, OR AS A CONSEQUENCE OF (c) 2 weeks | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Minutes | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19/85 to 2/25/85 , that (I) (we) lost
saw the deceased expire on 2/25/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. V. Parran MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
2/25 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. V. PARRAN | | | | | 22e. ADDRESS
Dept of Medicine FSKMC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
2/28/85 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
J. G. CONNELLY 300 MACE | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
Richard Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 85 05013 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) JOSEPH A. YAKEL | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR 02 26 85 | | | | 2b. HOUR 9:00 A.M. | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 4, 1916 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lutherville | | 13d. STREET ADDRESS / ZIP CODE 111 Margate Rd. 21093 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Adolph A. Yakel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve A. Bryan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 214-01-1255 | | 17 INFORMANT ADDRESS Westminster, Md. Donna Evergates-146 W. Main St. 21157 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) Coronary Artery disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that at (this hospital) attended the deceased from 02/27 , 19 85 , to 02/26 , 19 85 , that the (we) last saw the deceased alive on 02/26 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, that (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Paul D. Cardi DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/26/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul D. Cardi, MD | | | | 22e. ADDRESS MERCY HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-1-85 | | 23c. NAME OF CEMETERY OR CREMATORY Emory Methodist Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 ADDRESS 1050 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 1 1985 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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| FOR
1- STATE
REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 5 0 5 0 1 4
REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>John Vent</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 10 85</i> | | | | 2b. HOUR
<i>3:40</i> M | | | |
| 1 SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 26 00</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> | | IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY?
<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto. City</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Lutheran Hosp.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3502 Clifton Ave. 21229</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Unkn.</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>220-54-9128</i> | | 17. INFORMANT
<i>Mrs. Powell</i> | | | | ADDRESS
<i>- Same as #13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>2/10/85</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/10/85</i> to <i>2/10/85</i> , that (I) (we) last saw the deceased alive on <i>2/10/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Annisuzzo</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>2/10/85</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Annisuzzo</i> | | | | 22e. ADDRESS
<i>Lutheran Hospital of Maryland</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Removal</i> | | | | 23b. DATE
<i>2/13/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Anatomy Board</i> | | | | | | ADDRESS
<i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 22 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove accompanying Pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEFMAN

100% COTTON

8505015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME
(TYPE OR PRINT)
GEORGE YEP | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 20, 1985 | |
| 3. SEX
MALE | | 2b. HOUR
6:30
P M | |
| 4. RACE
CHINESE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 31 1921 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
64
YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WISCONSIN | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
US AIR FORCE | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | |
| 13c. CITY OR TOWN
ANNANDALE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Let Yep | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gin Lee | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
399-16-1202 | |
| 17. INFORMANT
ADDRESS
MARY JO YEP same as 13 a-e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Hepatocellular Carcinoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs
one week
one year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/11 , 19 85 , to 2/20 , 19 85 , that (1) (we) lost saw the deceased alive on 2/20 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
John E. Humphries | | 22c. DATE SIGNED
2/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John E. Humphries | | 22e. ADDRESS
Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
2/26/85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY
ARLINGTON VIRGINIA | |
| 24. FUNERAL DIRECTOR
NAME
DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA | | 25. DATE REC'D BY REGISTRAR
MAR 05 1985 | |
| 26. REGISTRAR'S SIGNATURE
John Davidson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director. Page 4 should be detached for use as the burial-transit permit. Please remove contents of pages 1, 2, and 3 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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REFERENCES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

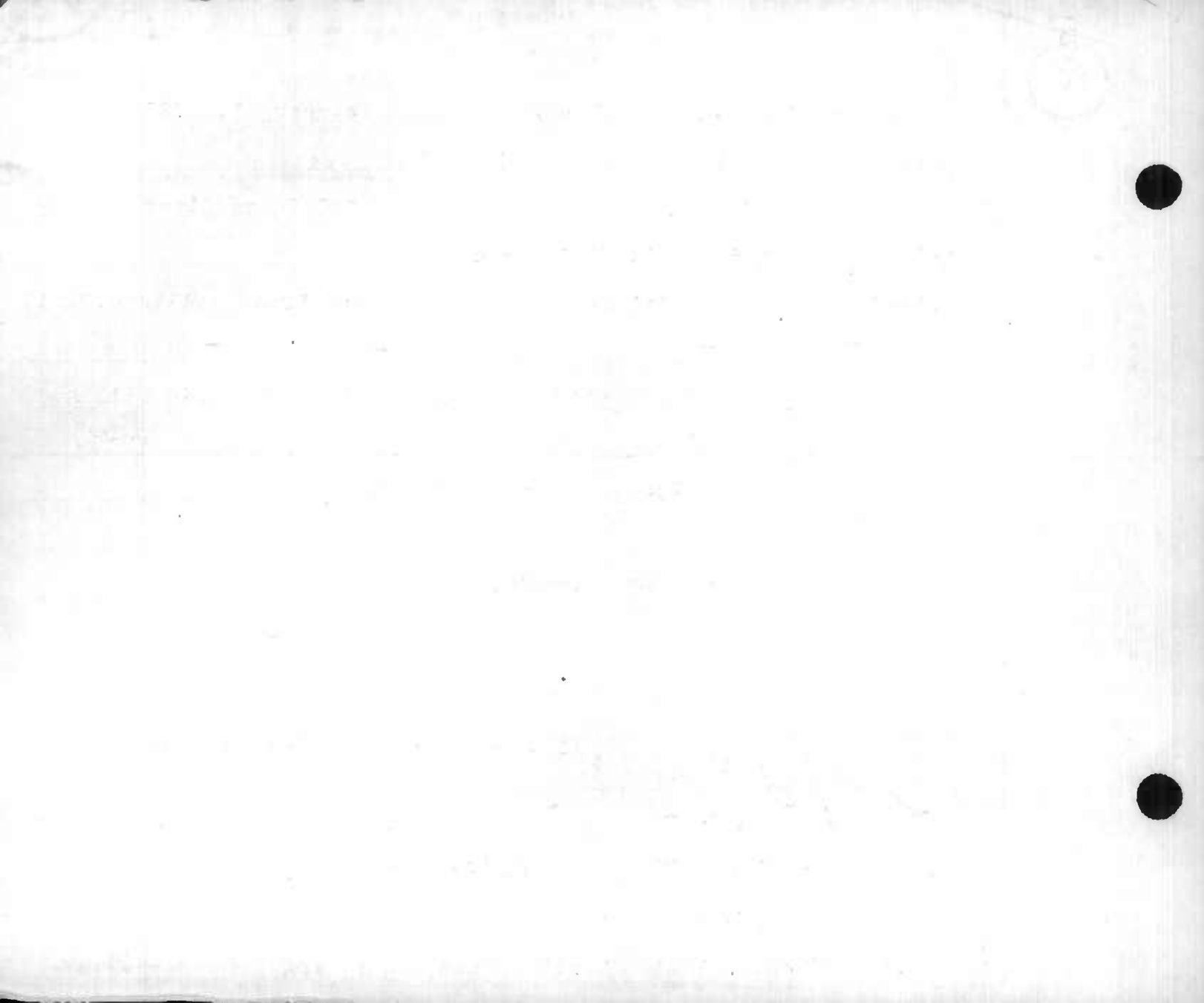
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 0 1 6

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Howard W. Young | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 1, 1985 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 15 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2460 Druid Hill Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-03-0820 | | 17. INFORMANT
ADDRESS
Rose Richardson 2460 Druid Hill Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cordial arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<u>Myocardial infarction</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-28-</u> 19 <u>82</u> , to <u>1-23-</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1-23</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Larry S. Perry M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2-1-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Larry S. Perry M.D.</u> | | | | 22e. ADDRESS
<u>107 E. Janss Ave. N. Suite 102</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
BURIAL | | 23b. DATE
2/5/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H Inc. | | | | ADDRESS
1101 E North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1985 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Shelia Davidson-Randall</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 85 05017 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH ZISSMAN | | | | | 2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 6, 1985 | | | 2b HOUR 2:30P.M. | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR APRIL 4, 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ROMANIA | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTO. | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a STATE MARYLAND | | | | | 13b COUNTY BALTO. | | 13c CITY OR TOWN BALTO. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST JACOB KRAMER | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b SOCIAL SECURITY NO. 216-52-8654 | | 17 INFORMANT ADDRESS TANNENZAPF MRS. BETTY TANNZAPF 3811 SEVEN MILE LANE 21208 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10
Pulmonary embolism | | | | | | | | | |
| 19a DATE OF OPERATION 2/7/85 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/24/83 P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2/6/85 to 2/6/85, that (I) (we) last saw the deceased alive on 2/6/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Dr. Maurice Feldman | | | | | DEGREE | | 22c DATE SIGNED 2-7-85 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Maurice Feldman | | | | | 22e ADDRESS 6610 Cross Country Blvd | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 2/8/85 | | 23c NAME OF CEMETERY OR CREMATORY ARLINGTON CEM | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. | | | | | 25a DATE REC'D. BY REGISTRAR FEB 13 1985 | | 25b REGISTRAR'S SIGNATURE | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |

CHESTERMAN EDWARD

POS. COTTON FIBRE

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